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# QUALITY ASSURANCE IN MENTAL HEALTH

National Human Rights Commission

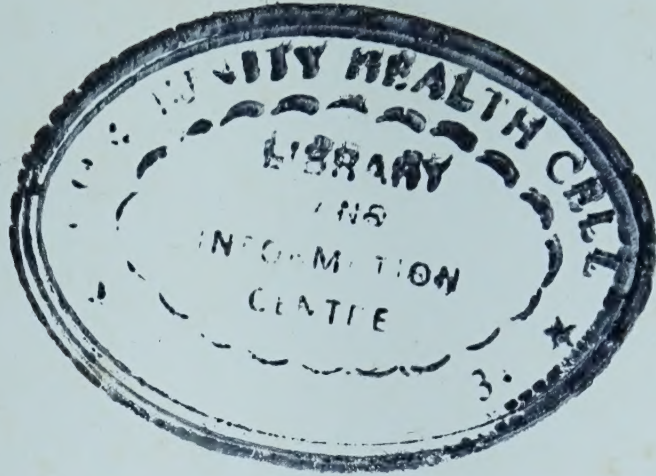
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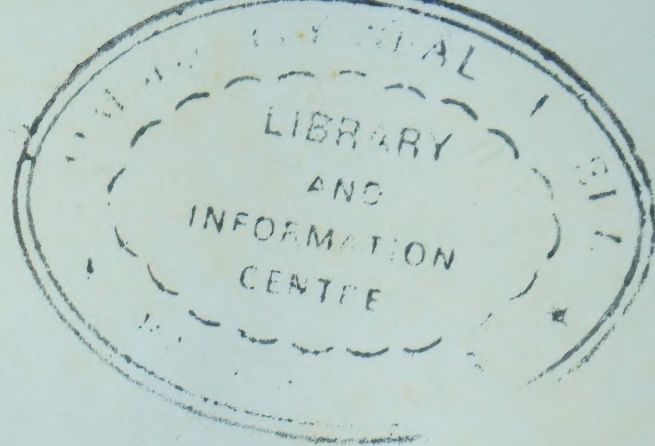
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# Quality Assurance in Mental Health



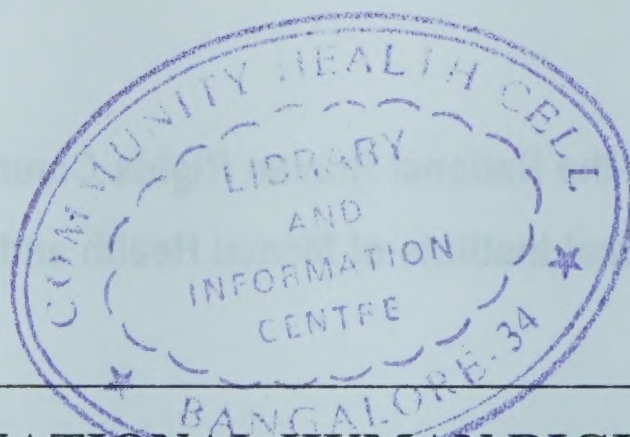
A Project of the National Human Rights Commission, India  
By the National Institute of Mental Health and Neurosciences,  
Bangalore



National Human Rights Commission  
Sardar Patel Bhawan,  
Sansad Marg,  
New Delhi-110001.



**1999 EDITION**



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**PUBLISHED BY THE: NATIONAL HUMAN RIGHTS COMMISSION**  
**SARDAR PATEL BHAWAN, SANSAD MARG, NEW DELHI-110 001**

**PRINTED AT: VEERENDRA PRINTERS, HARDHIAN SINGH ROAD,**  
**KAROL BAGH, NEW DELHI-5**

MH-100

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*Justice V.S. Malimath*

Member

National Human Rights Commission



राष्ट्रीय मानव अधिकार आयोग

सरदार पटेल भवन, संसद मार्ग, नई दिल्ली-११०००१ भारत

Sardar Patel Bhavan, Sansad Marg, New Delhi-1 INDIA

## COMMISSION'S CONCERN

National Human Rights Commission has been established for better protection of Human Rights. For achieving this object, several functions have been entrusted to the Commission. The Commission can, among others, review factors that inhibit the enjoyment of human rights, review the safeguards provided under the Constitution or any law for protection of human rights, undertake and promote research in the field of human rights and study the living conditions of the inmates of any institution under the control of the State Government where persons are detained or lodged for the purpose of treatment, reformation or protection and make suitable recommendation for protection and promotion of Human Rights.

The state of mental health care in the country as has come to the notice of the Commission is very poor and the living conditions are horrible. The Supreme Court, which had occasion to examine the state of affairs prevailing in mental hospitals at Ranchi, Gwalior and Agra, has issued several directions to remedy the shocking situation. Even then conditions did not improve. The Supreme Court has, therefore, entrusted to the Commission the responsibility of monitoring the implementation of its directions in regard to these Mental Hospitals. The Commission on its own visited some of the mental hospitals and was shocked at the state of affairs prevailing therein and the horrible conditions under which the mentally ill persons are living. The Commission noticed that some of the inmates were forced to remain in the mental hospital even after they were cured either because they had not received court's orders or because their relatives were not willing to come forward to take away the cured patients. The Mental Health Act also suffers from many lacunae, such as lack of adequate provisions to provide for rehabilitation of the cured patients. The number of mental hospitals in the country appears to be grossly inadequate to meet the growing demand. Some of the States do not have any mental hospitals. The quality of mental health care available in the mental hospitals is very poor. The Commission is quite concerned about the living conditions of the inmates of the mental hospitals established by the Governments. Unfortunately, most of the seriously mentally ill persons are incapable of complaining about their suffering on account of neglect, ill treatment or poor living conditions. The statutory safeguards provided in this regard have also proved ineffective. The Commission is, therefore, greatly concerned about the state of mental health care in the country.

The Fundamental/Human Right enshrined in Article 21 of the Constitution includes the right to live with human dignity and the right to health. The Supreme Court has ruled that maintenance and improvement of public health is one of the obligations that flows from Article 21 of the Constitution. The mentally ill have the Fundamental/Human Right to receive quality mental health care and to humane living conditions in the mental hospitals. When this precious human right of the mentally ill is threatened, it becomes the responsibility of the Commission to examine the problem and recommend appropriate remedial measures. It is with this object in view that the Commission took up for consideration the issue of quality assurance of mental health care in the country and I was put in-charge of the project. The investigation and research work was assigned to the National Institute of Mental Health and Neuro Sciences, Bangalore, the premier institution



*Justice V.S. Malimath*

Member

National Human Rights Commission



राष्ट्रीय मानव अधिकार आयोग

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on the subject. Dr. S.M.Channabasavanna, the former Director of NIMHANS, was entrusted with the responsibility as the Principal Investigator. Members of other related faculties of NIMHANS, viz. Dr. Mohan K.Isaac, Dr. C.R.Chandrashekhar, Dr. Mathew Varghese, Dr. Pratima Murthy, Dr. Kiran Rao, Dr. K.Redamma, Dr. K.Sekar, Dr. Subramanya Shetty and Dr. T.Murali, were co-opted by him as Co-Investigators.

The investigation team led by Dr. Channabasavanna prepared an elaborate questionnaire to elicit information on various aspects from all the mental hospitals and institutions in the country. A study team of experts nominated by Dr. Channabasavanna visited the hospitals, made a thorough inspection and had detailed discussion with the doctors and the administrators. They also held meetings with the patients and their relatives to understand their problems. After collecting the relevant data the same was analysed and intensely researched. They have produced a monumental report in which they have described the existing state of affairs, identified the failings and inadequacies and made comprehensive recommendations for achieving the object of ensuring quality mental health care in the country. They have made specific recommendations in respect of each State. Now that this blue print for assuring quality mental health care is ready, it is for the Governments at the Centre and the States to take prompt and effective measures to implement the same. The problem is serious and has been neglected too long. Hence, it is imperative to take-up remedial measures urgently and on a priority basis. Want of funds, it is hoped, would not be put forward as an excuse for not implementing the recommendations.

I must convey our gratitude to Dr. Gourie, Director of NIMHANS, for her whole-hearted cooperation and making available the faculty members and the facilities of NIMHANS at the disposal of the Principal Investigator for completing this stupendous task. Dr. Channabasavanna, the Principal Investigator, the former Director of NIMHANS, is an expert of great repute having earned national and international recognition for his contribution in the field of mental health. He has put his heart and soul and worked very hard in completing the enormous task. I was impressed by the leadership he provided and the way he extracted the maximum willing cooperation from everyone. I would like to convey our appreciation and gratitude to Dr. Channabasavanna and the Co-Investigators for the exemplary service they have rendered.

It was Justice Ranganath Misra, the first Chairman of the National Human Rights Commission, who took the initiative and entrusted the task to me. I am grateful to him for the confidence reposed in me. The difficult task could not have been accomplished but for the sustained support and encouragement of Justice M.N.Venkatachaliah, Chairman, National Human Rights Commission. I am grateful to him.

7<sup>th</sup> JUNE, 1999

(JUSTICE V.S. MALIMATH)



## PREFACE

Newer drugs, involvement of the family in treatment and modern methods of rehabilitation have considerably improved the quality of life of the mentally ill all over the world. It is unfortunate that in our country even after 50 years of independence, the mentally ill in institutional settings continue to be the silent sufferers. According to the World Health Organization guidelines, quality assurance of mental health care should cover the whole range of mental health activities with at least three levels of assessment and evaluation, namely policy, program and services.

There was no specific mental health policy for the country until 1982, when the National Mental Health Programme was accepted as the policy document. One of the objectives under this program was the improvement in the functioning of the mental hospitals in our country. Due to a lack of commitment on the part of politicians, policy makers, bureaucrats, and professionals, the National Mental Health Programme has not been taken up seriously. Whatever efforts have occurred have been rather sporadic in nature.

The quality of care remained at a nadir and resulted in several public interest litigations being filed against several hospitals. It is against this depressing scenario that Mr. Justice M. N. Venkatachaliah, Chairman, NHRC, then Chief Justice of the Supreme Court, passed orders to improve standards in the mental hospitals at Delhi, Gwalior, and Tezpur. He also ordered the immediate release of 'non criminal lunatics' who were suffering in several jails in West Bengal and directed that they be rehabilitated. These land mark judgements have become the guiding principles in the improvement of mental health care.

Mr. Justice V.S. Malimath has always had a soft corner for the sufferings of the mentally ill. During his tenure as the Chief Justice of the Kerala High Court, he initiated a unique orientation course for the judiciary. This was with regard to the Mental Health Act, 1987 and the role of the judiciary in improving quality of care for the mentally ill. It was noted as an innovative program, which had an impact on the care of the mentally ill. It resulted in judicial officers being in a better position to understand the plight of the mentally ill. Based on the requests he received from the public, he was responsible for the discharge of many patients who continued to be hospitalised despite improvement.

Personally, I have known Mr. Justice Malimath since he was a Judge of the High Court of Karnataka. He had invited me as a resource person for several of the orien-



tation programs conducted in Kerala. After retiring as the Chief Justice of the High Court of Kerala, he has been a member of the National Human Rights Commission. During the early part of his tenure as a member of NHRC, I met him at Delhi on several occasions while I was serving as the Director of NIMHANS. During one of my discussions with Mr. Justice Malimath and the then Chairman of NHRC, Mr. Justice Ranganath Misra, it was agreed that the NHRC would take up the cause of the mentally ill. It was suggested that NIMHANS could prepare a project to be funded by NHRC. Mr. Justice Malimath was instrumental in getting the project cleared by the NHRC. He kindly accepted to be the co-ordinator of the project.

During the preparation and implementation of the project, he has been a guiding force, always encouraging the team and giving his valuable suggestions. He participated as the Chairman of the Symposium on "Rights of the Mentally Ill", organised by the project team in Bhubaneswar at the National Conference of the Indian Psychiatric Society. Professionals were stunned by the video on the deplorable state of some of the mental hospitals in the country. At another workshop in Bangalore, he sat through the whole day discussing various problems faced by patients and their relatives.

Mr. Justice M. N. Venkatachaliah, Chairman, NHRC has also been taking keen interest in the project and has had discussions with the members of the team at Bangalore. These two judicial giants have taken up the mammoth task of improving the quality of life of the mentally ill in our country.

My team and I are very grateful to Mr. Justice Venkatachaliah and Mr. Justice Malimath for having supported this project. I am sure the Central Government and State Governments will seriously take up the cause of the mentally ill.

The report has been prepared in two parts. Part I provides a historical background to the development of mental health care in the country. It analyses the situation with respect to basic living conditions and compares the clinical services and staff issues across Government mental hospitals, private mental hospitals and general hospital psychiatric units. At the end of part I, a set of recommendations is presented, taking into consideration the suggestions made at numerous workshops and the observations of our team members.

Part II gives a detailed account of the conditions prevailing in the government mental hospitals in each of the States. Health being a concurrent subject, each State would be interested in knowing the state of affairs in their own State. It is earnestly hoped that each State Government would take up the recommendations suggested for immediate action in a stepwise manner, with the support of the Central Government.



I hope the report makes an impact on both policy and decision-makers at different levels both at the State and Central Government. I am sure that the NHRC would continue its support and involvement in monitoring the progress and pace of change in the mental hospitals.

Dr. S.M. Channabasavanna







## ACKNOWLEDGEMENTS

This is a landmark project which looks at various aspects of quality assurance in mental health care. The project, a major initiative of the National Human Rights Commission, was possible because of the collective efforts of the National Human Rights Commission (NHRC), New Delhi and the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore.

A large number of agencies and individuals have helped in the successful completion of this important venture.

The team members express their sincere thanks to the National Human Rights Commission and the State Human Rights Commission for co-ordinating the project.

The Chief Secretaries and Health Secretaries of various State Governments that have mental hospitals, greatly facilitated the project by arranging the teams' visits to the hospitals. The Directors and Medical Superintendents of the mental hospitals (Government and Private), Principals and Heads of Departments of Psychiatry of Medical colleges / General hospitals were instrumental in arranging for the completion of the exhaustive proforma. We thank all of them. The local administration and the staff of the individual hospitals were all extremely courteous and cooperative during the visits. Patients and their families spoke to the team members about issues relating to mental health service delivery. We thank them all for their efforts.

The National Human Rights Commission office co-ordinated most of the correspondence with the States at different stages of the project. We specially thank Mrs. Lakshmi Singh, Joint Secretary, NHRC for the same.

The team acknowledges with gratitude the Director/Vice Chancellor of NIMHANS (Deemed University), Dr. M. Gourie-Devi for her support. We thank the Departments of Psychiatry, Clinical Psychology, Psychiatric Social Work, Nursing, Health Education and Psychiatric & Neurological Rehabilitation for their support.

We thank all the NGOs who participated in the four zonal workshops conducted as part of the project.

The contribution of Dr. Sanjeev Jain in compilation of the historical aspects is acknowledged.

Dr. Vivek Benegal took a great deal of initiative and effort in designing the cover illustration. We are grateful to him for the same.



The press has given adequate coverage and has been helpful in sensitising the public on the rights of the mentally ill and about the project. We place on record our thanks to them.

We thank Ms. Veda, Ms. Anita and Mr. Ravi for secretarial assistance. Special thanks to Mr. Anand Kumar BM for his efforts and help in the final compilation of the report. To our 'Man Friday', Mr. Suresh Karanth, many thanks.

The team finally thanks all the persons who have helped in the project and not found mention here.



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# CHAPTER-1

## BACKGROUND

Major mental disorders take an enormous toll, in all societies, in human suffering, disability and loss of community resources. It is estimated that mental health problems the world over produce 8.1% of lost years of quality life, a toll greater than exacted by tuberculosis, cancer or heart disease, and neuropsychiatric disease makes up 6.8% of the Global Burden of disease (World Mental Health Report 1998). In India, about 20 to 30 million appear to be in need of some form of mental health care. Services for the seriously mentally ill have, until the last 2 decades, been rendered largely through the 37 Government mental hospitals. There are about 3500 psychiatrists, 1000 psychiatric social workers, 1000 clinical psychologists and 900 psychiatric nurses in the country. Within this limited manpower, the low professional to patient ratio and the overall low priority given to mental health care, the task of developing comprehensive mental health services appears daunting.

The last 20 years have witnessed the growth of private psychiatric institutions for the mentally ill, psychiatric services in general hospitals, the development of the National Mental Health Program with an emphasis on community services for the mentally ill, and the enactment of the Mental Health Act 1987, which regulates admission procedures. Newer and safer drugs for the treatment of a wide range of mental illnesses have become available.

What have these developments meant to the individuals with mental illness and their families? The mentally ill person deserves the same privileges enjoyed by any other human being. This also means a right to better and more accessible care, to good recovery, and increased hopes of reintegration into society. However, the stigma, residual disability and its intolerance, and more importantly, the inability of the mentally ill to protest against exploitation, have all made basic human rights of the mentally ill a major cause of growing concern.

Despite the developments outlined earlier, the core of residential care for patients with serious mental illness has so far been the mental hospital. Many such hospitals carry the labels, stigma and traditions that are more than a century old. Various attempts to change the ethos and functioning of mental hospitals have at best resulted in cosmetic or ephemeral changes, usually following professional or administrative initiatives. More serious attention has been drawn to the functioning of the mental hospitals and the gross atrocities against the mentally ill following several public interest litigations and Supreme Court initiatives, as well as media exposure. These have bared the gross neglect and exploitation of the mentally ill in



institutional settings.

There is thus a need to be proactive in ensuring that the basic rights of the mentally ill are protected both within treatment centers and in the community. Standards of mental health care in the country need to be evaluated and established. Ongoing monitoring mechanisms need to be evolved, especially in institutionalized settings. There is a need to examine how the developments earlier outlined can be translated into better, more comprehensive and integrated services for the mentally ill in the country.

This project on Quality Assurance in Mental Health Care was thus initiated by the National Human Rights Commission in 1997, and was executed by a ten member multidisciplinary team from the National Institute of Mental Health and Neuro Sciences. During the last two years, the services prevailing in the Government run mental hospitals, private psychiatric facilities and general hospital psychiatry units have been analyzed. This was done through an initial mail questionnaire survey, followed by field visits to the mental hospitals in the country. The teams interacted with various categories of personnel as well as with key administrators in each of the hospitals. Zonal workshops were organized during the field visits, to provide a forum for interaction between recipients of mental health care (patients and their care givers) and care providers. Following the field visits, a workshop for key personnel was conducted at NIMHANS.

The findings of the project reemphasize certain important themes that have been emerging from time to time with regard to mental health services in the country. They provide new insights from actual personal observations of the functioning of mental hospitals and the development of mental health services in different parts of the country. As we enter the new millennium, we hope that the insights provided and the earlier views consolidated will see the development of more humane, integrated and comprehensive care and fulfillment of human rights of the mentally ill.



# CHAPTER-2

## HUMAN RIGHTS AND MENTAL ILLNESS

Human Rights is about balancing the rights of all of us as individuals within the community (Australian Commission Report 1995). Rights on the one hand refer to the privileges the mentally ill should enjoy in society, and protection against infringement of these rights on the other. This includes the right to live, work as far as possible in the community, to privacy, and to lead a normal family life. *The seriously mentally ill are a very special group with disabilities. The concerns with this group are two fold - not only providing the privileges to live in society along with other citizens, but also ensuring their right to protection from exploitation.* Such exploitation includes economic, sexual or any other form of abuse - physical or psychological, and from degrading treatment, both within and outside institutions, in public or in private. Many of these rights are actually guaranteed in our Constitution. In 1948, The United Nations, through its Declaration of Human Rights, affirmed the basic principle that a mentally ill person should at all times be treated with humanity and respect for the inherent dignity of the person. Every person with a mental illness should have the right to exercise all civil, political, social and cultural rights (UN principle 1.4). The Declaration on the Rights of the Disabled, which includes persons with mental illness was adopted by the UN in 1975.

Mental health care and ensuring human rights should not confine itself to only remedial approaches (dealing with abuse and its prevention), but also recognize the contribution which mental health care can make to-

### Rights of the mentally ill

The mentally ill have a right to:

- the same fundamental rights as their fellow citizens including the right to a decent life, as normal and full as possible.
- legal safeguards against abuse
- appeal
- necessary treatment in the least restrictive set up and as far as possible to be treated and cared for in the community
- rehabilitation
- personal autonomy, privacy, freedom of communication,
- education
- training
- economic and social security
- family and community life
- employment
- protection against exploitation and discriminatory, abusive or degrading treatment
- assistance, including legal, to protect their rights



wards the fulfillment of human rights and meeting the rights of the community to such care as necessary.

In order to reach such an ideal situation, it is important to understand the evolution of the care for the mentally ill in the country. This includes the transition from institution to community care, legal provisions and the mechanisms visualized to protect human rights, the forces that have effected change. The possible reasons for a lack of consistency and maintaining the pace of change, need to be examined. Community linkages and networking for effective delivery of mental health care to all those in need to be developed.



## **CHAPTER-3**

### **UNDERSTANDING OF MENTAL ILLNESS AND THE BIRTH OF ASYLUM**

In the Middle Ages, madness was seen as a manifestation of possession by the devil or evil spirits, heresy or some form of immorality. The 16<sup>th</sup> and 17<sup>th</sup> centuries saw large-scale institutionalization of those considered lunatic along with rogues, vagabonds and disorderly persons. By the 19<sup>th</sup> century, the science of psychiatry was well established. A shift to moral treatments and more humane care of the mentally ill was propounded. In the current century, a greater understanding of the etiology, manifestation and newer treatments for a variety of mental disorders has emerged.

The concept of asylum was initially premised on the view that the most appropriate way to care for people with mental illness was in a protected and segregated environment. However, the limited treatment regime meant that very few people moved back into the community. Any advantages that asylums may have offered were outstripped by the disadvantages of confinement, stigmatization, overcrowding and lack of personal freedom.

In the mid twentieth century, social pressure for reform, abetted by advances in medical technologies and financial burden imposed by large institutions contributed to the change in policy direction known as de-institutionalization. Unfortunately hospital and community services have tended to compete for funds and have proved unwilling to co-operate in service provision (Australian Commission 1995). While residential care for the acutely and seriously mentally ill is necessary, the evolution of such systems of care and their relevance in the present day need to be examined.

#### **Evolution of Institutional Care in India**

While in some countries the concept of asylums initially grew from the premise that the most appropriate way to care for people with mental illness was in a protected and segregated environment, in other countries asylums were meant to protect the society from the mentally ill. Sharma (1990) has reviewed the history of the mental hospitals in the Indian subcontinent in different phases of development. Although there have been some references to humane care of the mentally ill during the time of Ashoka, the establishment of asylums during the reign of Alauddin Khilji in the 15<sup>th</sup> century, services brought by the Portuguese to India during the 17<sup>th</sup> century, the official beginnings of modern psychiatry in India were during the colonial rule by the British.

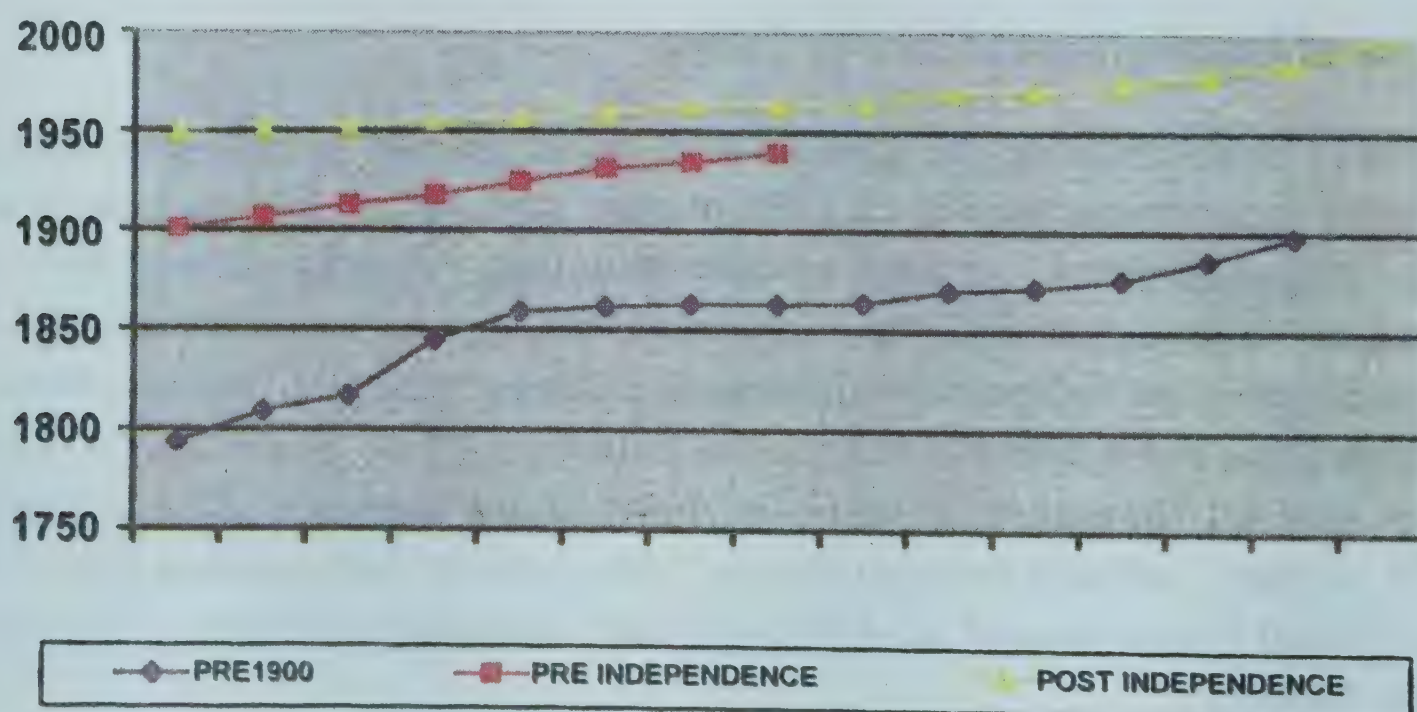
The beginnings of 'services' for the mentally ill through mental asylums was to



protect the community from the insane. The growth of mental asylums needs to be reviewed in the context of the political climate and the psychosocial turmoil during the latter half of the 18th century. The following section excerpts heavily from the reviews provided by Ernst (1987) of the development of native lunatic asylums in early nineteenth century British India. The establishment of the lunatic asylum was seen as a 'less conspicuous form of social control' by the British. The first reference to a mental hospital in India dates to a reference of Lord Cornwallis to the first mental hospital in Calcutta in 1787 by a surgeon George M Kenderline. However this institution was not recognized by the medical board as this surgeon had earlier been dismissed from service because of neglect of duty. According to the Bengal Medical Board 1788, a private asylum was started by Surgeon William Dick for the East India Company, which served both 'insane officers and private men, and civilians of various stations',. Run as a private establishment, Dick's establishment and two others which came up in Bombay and Madras were viewed as "being extremely beneficial....to the community at large by affording security against the perpetration of those Acts of violence which have been so frequently committed by unrestrained lunatics" (Ernst). The tendency of these private institutions to overcharge the Government for the maintenance of their patients, and the fact that their premises were poorly maintained, prompted the decree by the Court of Directors of the East India Company in 1802 to set up lunatic asylums for the reception of both criminal and free wandering insane Indians in Bengal. The genesis of various asylums is outlined in Figure 1.

By 1820, a number of lunatic asylums for the exclusive reception of Indians and the lower strata of Eurasians, distinct from separate services for the English were established.

**Figure 1: Establishment of mental hospitals in India**



In the Bengal Presidency provision for the safe custody and care of mad persons had been made in Calcutta, Benares, Dacca, Murshidabad and Patna. Each of



these institutions contained between 35 to 170 people, the largest being in the Calcutta area. Under the Government of Madras, one asylum in the capital itself as well as in Chittoor, Tiruchirapalli and Masulipatnam respectively had been constructed, while Bombay secured its 'public nuisances' in only one small institution in Kolaba.

### **The Bengal Enquiry of 1818**

The 1818 enquiry of Bengal occurred shortly after the 1815/16 Select committee revelations on the better regulation of madhouses in England, and only a decade after the setting up of the native asylum in Bengal in 1802. The Medical Board emphasizing the real nature of such institutions said that the lunatic asylum was "not merely a place for the detention and safe custody of individuals dangerous to the peace of society, but a retreat, providing for the tender care and recovery of a class of innocent persons suffering under the severest of afflictions to which humanity is exposed". The findings of the Medical Board are summarized by Ernst. "The buildings are low and damp and not half-large enough for the number of patients, to which must be attributed the numerous deaths which occur".

The Rasapagla Asylum in Calcutta was described as 'a worse situation could not be found'. The Murshidabad Asylum was regarded as wholly unfit, the building 'altogether a wretched place even in its best state... and now falling to ruins'. The Patna asylum was said to 'labor under disadvantages greater even than those pointed out existed in Murshidabad'. It was erected on low ground close to the breeding ground of miasmas, and was provided with bad brackish water. The death rate was consequently an enormous 52%. In the Bareilly asylum, 105 patients were accommodated in 29 cells, with four persons often confined in a cell not bigger than 10 x 8 feet. The Benares asylum was 'on a scale so contracted and insufficient and in appearance bore more resemblance to a prison than of an asylum for lunatics'.

The diet condition in respect to food supplies were regarded as insufficient and unwholesome. The number of staff employed, their attitude and behavior towards the patients, the measures taken for the upkeep of discipline and order as well as of the prevention of violent actions were further aspects seen to determine the proper management of the institution and to guarantee the proper care of its inmates.

The asylum was to guarantee attentive and humane conduct of the keepers and subordinate attendants. With regard to restraints, The Board recommended that 'unnecessary coercion be never used and that irons be not employed except in extreme cases and then only manacles or light leg chains'. Ernst summarizes the 1818 inquiry as leading to 'only moderate control of gross abuses, rectification of the institution's physical defects whenever practicable, and strongly expressed avowals to humane and moral treatment, proper gender segregation and classification of lunatics'.



The 'First Phase' (Sharma 1990) of development of mental hospitals in India thus witnessed the genesis of about 13 facilities, initially in the private sector and later by the administration.

In the 'Second Phase' of development, when the Crown took over the powers from the East India Company in 1858, the philosophy of segregating the mentally ill from society continued, and the asylums functioned predominantly as centers of detention. Many of the mental hospitals currently in existence were started during the middle and latter part of the 19<sup>th</sup> century (refer Figure 1). Ernst concludes that the conditions in the mental hospitals largely depended "upon the superintendent in charge, the general state of the buildings and the understanding between the staff and the inmates".

### **1840 - Investigation into the State of Native Lunatics in Bengal**

This second investigation followed a suggestion of a Central Asylum some years earlier, along with suspicions of the European Superintendents' petty corruptions and the highly divergent cure and death rates in the asylums. The highlights of these findings were a varying quality of conditions, dependent on each superintendent's personal style of functioning, management and their individual commitments to their patient's fate. The material facilities available at this time in most establishments were still very restricted. Consequent to this Enquiry, the asylums at Benares, Delhi and Bareilly were condemned to be rebuilt. Around this time, it appeared evident that diet, occupation for patients and the interest of the treating doctors were all vitally important. Paradoxically at around the same time Surgeon Paton in Delhi was practicing what he considered a very effective approach of enforcing discipline and industriousness through 'food restriction' as punishment, which was reflected in not altogether favorable cure and increased death rates.

While these enquiries focused on the responsibilities of the administrators, the Indian assistants and the role of head keepers received no attention in the English documentation of Indian Asylums (Ernst 1987).

### **The Early 1900's**

In the 'Third Phase' of development, mental hospitals, hitherto under the charge of the Inspector General of Police, came under the charge of civil surgeons. Specialists in psychiatry were required to be posted as full time officers in these asylums. Central supervision of all lunatic asylums was contemplated in 1906, and formalized under the Indian Lunacy Act of 1912. Berkeley Hill, the then Superintendent of the Central European Hospital (now the Central Institute of Psychiatry) at Ranchi made significant contribution to an attitudinal change towards these institutions. He persuaded the government in 1920 to change the names of the lunatic asylums to mental hospitals. He highlighted the need to associate social scientists with the care



of the mentally ill and the first efforts to train psychiatrists and psychiatric nursing personnel began during this period. An Association of the Medical Superintendents of Mental Hospitals was also established and a Manual for Superintendents of Mental Hospitals in the country was formulated in 1930, outlining procedures for care, administration, and treatment, as well as defining roles of different levels of staff.

## Mapother's Report

An eye-opener into the needs of the mental hospitals is the 40 page report by Mapother submitted in 1938 (Jain et al 1999). This compared the state of psychiatric services in London and India. The report contrasted the difference in psychiatric bed ratios of 1:200 in London as compared to 1:30,000 in India. 5/8 of all beds for medical illnesses were for the psychiatrically ill in London, in contrast to 1/7 of the beds in India. Shortage of bed provision vis a vis the demand, along with overcrowding was apparent. Yerawada had 29% overcrowding (1058 patients against a bed strength of 817), and Madras 93% overcrowding (1433 against a sanctioned strength of 744). In Agra (617 beds) annual death rate was 123/1000. Mapother cited that 'indifference was stated commonly as a reason but this must be fought against'. He was savagely critical of the Indian Medical Service. 'The Indians have been unable to exercise the authority to enforce change.... The only thing they know is to lock up the worst patients'.

Mapother was extremely critical of the state of the Mental Hospitals and compared them on a scale of 'badness'. "Most mental hospitals are desolate waste, based on the conception that the insane are indifferent to ugliness and are destructive". He cited Madras as the best of the 'typical' mental hospitals in India (excluding the European Hospital at Ranchi and the Mysore Mental Hospital which he described as exceptional). He described the mental hospital at Pune as 'inspired by the PWD concept of a lunatic', with 'open air cages'.

Mapother outlined a program for reorganizing services for the mentally ill in India and made 12 observations and recommendations:

### I. Admission procedures:

1. Brief detention /observation exists, but no short admission beds.
2. Voluntary admission exists, but no beds in public wards.
3. India not ready for non-volitional order on account of corruption. Every case should be seen by a magistrate before and after admission for detention.
4. Certification for detention should be limited to experts with recognized qualifications.



II. Visiting committees to be set up.

III. Deputy to Public Health Commission with knowledge of psychiatry to be appointed.

IV. Institutional facilities to include:

1. Increase in beds irrespective of all pressures
2. Specialized services especially for the criminal, mentally retarded and involuntary patients.
3. Classes of service to include:

Psychiatric clinic in Government hospitals and beds for mentally ill patients.

Short treatments lasting for 1 month.

Separate facilities for chronic mentally ill.

‘Colonies’ for those not requiring confinement and capable of work.

V. Improvements of conditions for chronic patients.

VI. Increase in undergraduate education in mental health.

VII. Diplomas to be started.

VIII. Teachers/researchers to have a stint of training abroad.

IX. Well trained staff and mental health nurses required.

X. Need to introduce social workers in mental hospitals.

XI. Organized occupation of patients and training of those who supervise them is crucial.

XII. Survey and public propaganda as to the true incidence of mental illness and whether certain illnesses could be prevented.

## **Moore Taylor's Report**

In 1946, Col. M Taylor, Superintendent of the European Mental Hospital at Ranchi as a member of the Health Survey and Development Committee (Bhore Committee) was asked to survey the mental hospitals and his report was based on his observations of 19 mental hospitals with a bed strength of 10,181 (Taylor 1946). Taylor summarized his observations as follows: “ The majority of mental hospitals



in India are out of date, and are designed for detention and safe custody without regard to curative treatment. The worst of them the Punjab Mental Hospital, the Thana Mental Hospital, the Agra Mental Hospital and the Nagpur Mental hospital savour of the Workhouse and the Prison and should be rebuilt. The remainder should be improved and modernized in accordance with the suggestions of the Medical Superintendents..... The conditions of many hospitals in India today are disgraceful and have the makings of a major public scandal”.

Many of Taylor's observations ratified the earlier observations made by Mapother. His recommendations included:

- Qualified and trained psychiatrists to head mental hospitals.
- Need for adequate staffing ('Every mental hospital which I have visited in India is disgracefully understaffed..... The policy of increasing bed capacity, which incidentally has led to gross overcrowding in most of the hospitals rather than personnel, has been stressed in the past, but the cure of mental patients and the prevention of mental diseases will not be accomplished by the use of bricks and mortar').
- Post graduate training courses with adequate emphasis on prophylaxis and prevention in line with the principles of modern preventive medicine.
- Uniformity in undergraduate training in psychiatry.
- Mental hospitals should be teaching institutions and attached to the Medical Colleges.
- Need for a mental health service, with improvement in the status, pay, and conditions of service of the medical staff, with increased opportunities for purely professional work.
- Urgent necessity for better trained nurses.
- Increase in the number and quality of ward personnel. Theoretical and practical instruction for both nurses and ward personnel.
- Need for a more systematic and better conceived plan of work therapy and diversional therapy.
- Special homes for patients with physical problems (medical or nursing) under the supervision of the Medical services (Taylor felt that more than 50% of the patients in mental hospitals could be cared for in such homes).
- Need for outdoor clinics in Mental Hospitals.
- Services addressing mental health issues in schools, child guidance clinics,



Borstal institutions, juvenile homes and remand homes.

- Psychiatry should not be segregated, but form links with other medical specialties (However Taylor cautioned that to open psychiatric clinics in General Hospitals before there are trained personnel to conduct them would be bad propaganda). Once this was achieved the general hospital could bear its share of mental illness treatment and prevention activities.

- Need to create goodwill about mental hospitals by 'letting the community know that the mental hospital has a real service to be given; convincing people that they need what it has to offer; making it easily obtainable; making people glad they can have what the institution has to offer'.

Taylor placed the onus of improvement of mental services on the government. "This is a suitable time for Government to take account of stock, overhaul resources, and rechart the course for the next 30 years".

## **Treatments in Psychiatry**

During these thirty years that followed older methods of treatment such as physical restraint, hydrotherapy, leucotomy and insulin coma, gave way to pharmacological treatments. With the advent of chlorpromazine in the 1950's and the subsequent discovery of antidepressants, mood stabilizers and subsequently newer antipsychotics with fewer side effects, there have been dramatic changes in treatment of mental disorders. Modern pharmacotherapy and physical methods of treatment including electroconvulsive therapy, the advent of diagnostic tools such as EEG and imaging have led to better diagnosis of organic disorder, quicker recovery of psychiatric illnesses, and a better chance of rehabilitation and reintegration into society.



# CHAPTER-4

## BEYOND MENTAL HOSPITALS

### **The De-institutionalization Movement**

Since World War II there has been a concerted effort in many countries, including the USA and the UK towards de-institutionalization and the development of comprehensive community services. In some countries such as Italy, mental hospitals have been closed down.

### **Development of Community Psychiatry: Bhore, Mudaliar, Srivastava Committees.**

The Alma Ata Declaration emphasized that 'the community must perceive health as one of its major efforts and not relegate it to Government efforts alone. This can be viewed as the foundation for community care. The community psychiatry movement in India is comprehensively reviewed in the Proceedings of the Indo-US Symposium on Community Mental Health (Murthy and Burns 1992). The growth needs to be reviewed against the backdrop of the recommendations of the Bhore Committee (1940) and the Mudaliar Committee (1962). The Bhore Committee recommendations for mental health, based on Moore Taylor's report referred to earlier, called for improvements in mental hospitals and the need for medical and ancillary mental health personnel. The Mudaliar Committee envisaged development of psychiatric units in all district hospital in the subsequent 10 years. The Indian Medical Council mandates the setting up of Departments of Psychiatry at medical colleges.

### **National Health Policy**

The change in health policy from a vertical program to programs involving the community resulted in the National Health Policy of the Government of India in 1983 with a thrust towards primary health care; decentralization of services and primary, secondary and tertiary prevention initiatives, including rehabilitation. So far, the thrust had been only on physical illnesses and mental health services lagged behind. The epidemiological findings of severe mental morbidity (10-20 /1000) and minor mental morbidity (20-50/1000), the Raipur Rani and Sakalwara experiments showing feasibility of providing rural mental health care, the inadequate care in mental hospitals and the concerns of professional bodies resulted in the adoption of the NMHP by the Central Council for Health in 1982.

### **National Mental Health Program (NMHP)**

The main objectives of the NMHP were:

1. To ensure availability and accessibility of minimum mental health care for



all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population.

2. To encourage application of mental health knowledge in general health care and social development.

3. To promote community participation in the mental health service development and to stimulate efforts towards self help in the community.

As part of the NMHP, workshops for training of trainers, state level planners, mental health professionals, PHC personnel and State administrators were conducted. Voluntary organizations were involved and steps for involving the community were undertaken (NMHP Progress Report 1982-1988). An ICMR center for advanced research was setup in Bangalore. A model District Mental Health Program was set up in the Bellary district of Karnataka. The NMHP envisaged operationalization of the program at least in one district of every state in the country within a reasonable period of time. This was discussed and reviewed in a recent meeting of health planners held in Bangalore in November 1998.



# **CHAPTER-5**

## **SHIFTS FROM CUSTODIAL CARE**

### **Growth of Private Psychiatric Institutions.**

Demand for inpatient facilities for the mentally ill, the poor condition in the mental hospitals and the stigma attached to mental hospitals have all led to the development of private psychiatric facilities catering to the mentally ill. It is estimated that there are about 40-50 privately run psychiatric facilities in the country, with bed strengths ranging from 8-10 upto 100 - 300.

### **General Hospital Psychiatry Units**

The development of general hospital psychiatry units, a movement which started in the 1930's, but intensified in the 1960's seemed to indicate a shift in the locus of psychiatric care to this more acceptable and accessible area. In General Hospital psychiatry units (GHPU's), relatives can stay with patients, admissions are voluntary and better liaison with other medical specialties is possible. Many such centers have come up throughout the country and account for about 3000 beds.

### **Voluntary Agencies - Emerging Role in MH Care**

While there have been a large number of non-Governmental, voluntary social service organizations all over the country, their involvement in mental health care is relatively recent. There are a few such organizations primarily working in this area, including day care centers, halfway homes, de-addiction services, special services (for the mentally retarded and the aged) etc., crisis intervention and suicide prevention. The formation of self-help groups of patients and their families, the first being AMEND (Association for the Families of Mentally ill Individuals) in 1992 is another significant development.

There has been a shift in focus from mental illness to mental well being more recently, especially in vulnerable populations. Such programs include the School and College Mental Health Program providing training to teachers and the National Commission for Women Project on Mental Health of Women in Custody.

### **Laws relating to psychiatry and their influence on mental health care**

Mental asylums in India under the British were greatly influenced by ideas and concepts as prevalent in England and Europe at that time (Sharma, 1990). In the middle of the 19th century the Lunacy Regulation Act of 1853, Lunatic Care and Treatment Amendment Act 1853 and Lunatic Asylums Amendment Act 1853,



replaced the earlier Act for Regulating Private Mad Houses of 1774 and Country Asylum Act of 1808. In 1858, the East India Co., enacted the first Indian Lunacy Act of 1858. The Act contained instructions and guidelines for admission and treatment of lunatics.

The adverse publicity about the asylums in the country both locally and abroad, and the idea generated of central supervision in 1906 were forerunners of the Indian Lunacy Act of 1912.

The Bhore Committee recommendation suggested that the Indian Lunacy Act had out lived its usefulness.

The Mental Health Act 1987 introduced changes based on modern concepts in mental health. Outmoded terms were replaced, admission and discharge procedures simplified, decertification by Board of Visitors no longer deemed necessary and licensing of psychiatric hospitals mandated. Mental retardation was removed from the definition of mental illness.

The Mental Health Act applies to Government psychiatric hospitals, private psychiatric hospitals and psychiatric nursing homes. It does not apply to patients in psychiatric wards of general hospitals. Both Central and State Mental Health Authorities are required to be established to regulate and monitor psychiatric services as well as to co-ordinate a wide range of mental health related activities. Responsibility of different groups, police, and public in ensuring speedy treatment of the mentally ill are delineated.

The Mental Health Act recommends the establishment of separate facilities for those under the age of 16 years, for persons addicted to alcohol and other drugs which lead to behavioral changes, for those who have been convicted of any offence and those belonging to such other class or category of persons as may be prescribed.

Human Rights gets a passing mention in Chapter VIII, Section 81.

Despite the enactment of the Mental Health Act in 1987, it is a sad story that magistrates in some parts of the country, still refer cases under the Indian Lunacy Act.

### **Persons with Disabilities Act (PDA)**

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 includes chronic mental illness as one of the disabilities. The benefits prescribed for other disabilities, except job reservation is also applicable for chronically mentally ill. A minimum of 40% disability is the eligibility criteria for all disabilities. Translating this to chronic mental illness is currently receiving attention, including from international agencies such as the World Health Organization and other national professional bodies.



## Workshops for Medical Superintendents: A Summary

Four workshops on improvement of mental hospitals in the country were held during a 30-year span between 1960 and 1990. These included the first Conference of Superintendents of Mental hospitals in India held in November 1960 at Agra, WHO workshop on "Mental Hospitals in India: Present status, resources and future needs at Ranchi in February, 1986, Workshop on Mental Hospitals in India held as part of the NMHP implementation at NIMHANS, Bangalore in March 1988, and a WHO workshop on Future Role of Mental Hospitals in Mental Health Care in India held at IHBAS, New Delhi in December 1990. The recommendations of each of the workshops are summarized in Table 1.

Similar themes ran through each workshop.

The primary areas of concern were:

- Improvement of living conditions.
- Improvement of hospital infrastructure and function.
- Definition of roles of various personnel.
- Training of staff in mental hospital.
- Provision of outpatient and emergency services.
- Provision of day care and rehabilitation services.
- Extended role of mental hospitals in teaching and training.
- Need for special services (child, old age, drug and alcohol, criminal mentally ill)
- Need for development of GHPUs.
- Need for development of alternative services and linkage in the community for mental health care.
- Undergraduate and postgraduate training and refresher courses in psychiatry for other professionals.
- Mechanisms for internal and external monitoring.

The workshops were attended and recommendations formulated mainly by mental health professionals. However, few of the recommendations have resulted in visible changes.



**Table 1. Summary of workshops on improving care in Mental Hospitals.**

	Agra (1960)	Ranchi (1986)	Bangalore (1988)	New Delhi (1990)
Mental Hospitals	<ul style="list-style-type: none"> <li>* Remodeling – modernizing building</li> <li>* Improved treatment facilities &amp; amenities</li> </ul>	<ul style="list-style-type: none"> <li>* Names to be changed to Mental Hospital and Psychiatric centers</li> <li>* Bed strength not to exceed 400</li> <li>* Diet - 3000 cals / rural adults</li> <li>* 2800 cals / urban adults</li> </ul>	<ul style="list-style-type: none"> <li>* Improve living conditions</li> </ul>	<ul style="list-style-type: none"> <li>* 1000 sq. ft/person</li> <li>* good sanitation &amp; toilet facilities as per latest norms</li> <li>* Adequate water and electricity supply</li> <li>* Modern kitchen.</li> <li>* Stigmatizing terms to be discontinued.</li> </ul>
	<ul style="list-style-type: none"> <li>* Adequate Staffing</li> <li>* Short refresher courses for all levels of employees</li> </ul>	<ul style="list-style-type: none"> <li>* Staff for 100 / 200 bedded facility outlined</li> <li>* 2-4 week training for all personnel</li> <li>* Hospital attendants High school /SSG + 6/12 training in mental health</li> <li>* Redefine Mental Hospital's, psychiatrists', medical officers' nurses', other staffs' role in keeping with NMHP</li> </ul>	<ul style="list-style-type: none"> <li>* Enhance know-how skills of hospital functionaries, continuing professional education inservice training</li> <li>* Job description</li> </ul>	<ul style="list-style-type: none"> <li>* Ongoing training for psychiatrists, nurses, ward attenders</li> <li>* Psychiatrists and para-professionals to undergo refresher courses - either at Bangalore or Ranchi.</li> <li>* Definition of job responsibility</li> </ul>
			<ul style="list-style-type: none"> <li>* Mental Hospital service manual.</li> <li>* Strengthen administration training, management planning</li> <li>* Full time administrative officer.</li> </ul>	<ul style="list-style-type: none"> <li>* Overall change under of superintendent.</li> <li>* Ongoing training for medical superintendent on administrative responsibilities</li> <li>* Annual meeting of medical superintendents to discuss problems - administrative, professional and legal</li> </ul>
		<ul style="list-style-type: none"> <li>* Active OPD and 24 hour emergency services</li> </ul>	<ul style="list-style-type: none"> <li>* OP/Emergency services necessary</li> <li>* IP care for acute and chronic</li> </ul>	



	Agra (1960)	Ranchi (1986)	Bangalore (1988)	New Delhi (1990)
	<ul style="list-style-type: none"> <li>* Separate facilities for chronic patients</li> </ul>	<ul style="list-style-type: none"> <li>* Transfer chronic patients to allied facilities</li> <li>* Rehab. Facilities.</li> <li>* Free family accommodation in Dharmashala</li> </ul>	<ul style="list-style-type: none"> <li>* Education of families</li> <li>* Day care facilities</li> <li>* Rehab facilities regular audits with simple record and reporting system</li> </ul>	
	<ul style="list-style-type: none"> <li>* Uniform system of record maintenance with standard nomenclature for diagnosis as adopted by WHO</li> </ul>		<ul style="list-style-type: none"> <li>* Proforma to be prepared for MH review visits</li> </ul>	<ul style="list-style-type: none"> <li>* Committee of zonal experts to visit hospital annually for external quality assurance</li> </ul>
		<ul style="list-style-type: none"> <li>* No new mental hospitals to be established unless they meet minimum standard of budget, staff and psychiatry facilities</li> </ul>		<ul style="list-style-type: none"> <li>* No new mental hospital unless visitors standards of budget, staff and physical facility met.</li> </ul>
Treatment	<ul style="list-style-type: none"> <li>* Restraint in use of tranquilizers</li> <li>* Import of modern psychiatric drugs</li> <li>* Impetus for indigenous manufacture</li> <li>* ECT/EEG and other electromedical equipment used in psychiatry to be manufactured</li> </ul>	<ul style="list-style-type: none"> <li>* Free drugs in OPD</li> <li>* Essential supply of common drugs</li> <li>* Discourage polypharmacy</li> <li>* Judicious use of ECTs</li> </ul>	<ul style="list-style-type: none"> <li>* Crisis intervention programs</li> </ul>	<ul style="list-style-type: none"> <li>* Diagnostic facilities including EEG to be made available</li> </ul>
• Extended role of mental hospital	<ul style="list-style-type: none"> <li>* Link mental hospitals with medical colleges</li> </ul>	<ul style="list-style-type: none"> <li>* Teaching facilities in all mental hospitals</li> </ul>		
• Alternative Services	<ul style="list-style-type: none"> <li>* GHPUS</li> <li>* Special Schools for training for Mental Retarded</li> <li>* Day Hospitals when practicable</li> </ul>	<ul style="list-style-type: none"> <li>* GHPUs 25-50 beds at district level</li> <li>* 5-10 beds at sub-district level</li> <li>* Community based programs to supplement occupational and rehabilitation centers</li> </ul>	<ul style="list-style-type: none"> <li>* Mental health care through PHCs</li> <li>* Linkage with developmental programs.</li> <li>* Involvement of voluntary agencies</li> </ul>	



	Agra (1960)	Ranchi (1986)	Bangalore (1988)	New Delhi (1990)
• Training	<ul style="list-style-type: none"> <li>* Increase in number of trainees</li> <li>* Additional PG centers</li> <li>* State Govt. Sponsorship of personnel for training</li> <li>* 3 months training for medical auxiliaries (in Psychiatry) working in medical and health institutions</li> <li>* Refresher courses for Gps</li> <li>* Focus on training in psychology and psychiatry in undergraduate curriculum</li> </ul>		<ul style="list-style-type: none"> <li>* Public education activities, community awareness, sensitization of decision-makers of Department and State .</li> </ul>	<ul style="list-style-type: none"> <li>* Re-orientation of medical officer's, GP's clinicians and non-medical mental health professionals</li> </ul>
• Mental Health Act and its directives	<ul style="list-style-type: none"> <li>* Amendments to Mental Health Bill suggested</li> <li>* No non-criminal lunatics to be kept in jail.</li> <li>* Separate facilities for criminally mentally ill</li> </ul>		<ul style="list-style-type: none"> <li>* CMHA to be appointed</li> <li>* SMHA to be appointed</li> </ul>	<ul style="list-style-type: none"> <li>* special facilities for children, elderly, drug users, mentally retarded.</li> </ul>
• Special Population	<ul style="list-style-type: none"> <li>* Establishment of child wards</li> </ul>	<ul style="list-style-type: none"> <li>* Separate facilities for children, aged, alcohol and drug use</li> </ul>	<ul style="list-style-type: none"> <li>* Special clinics and services</li> </ul>	
• Others	<ul style="list-style-type: none"> <li>* Improve pay, promotional avenues and service prospects in the field of psychiatry</li> <li>* Travel fellowships for visits abroad</li> </ul>	<ul style="list-style-type: none"> <li>* Bus/ rail concession for mentally ill</li> </ul>	<ul style="list-style-type: none"> <li>* State level mental health reports</li> <li>* Identification of regional zonal centers for training monitoring and evaluation of the national mental health program.</li> <li>* Appointment of regional coordinating authority</li> </ul>	



It is interesting however that in states where advisory committees were appointed, for example in Gujarat and Maharashtra, where the Chief Investigator of this project, Dr. SM Channabasavanna was part of the advisory committee, some positive changes have occurred with resultant improvement in functioning.

A recent workshop for Medical Superintendents, organized by the Ministry of Health and Family Welfare, Government of India was held in February 1999 in Bangalore to evolve minimum standards of care in mental hospitals.

### **Public Interest Litigation**

The quickest and dramatic changes in mental health care especially in institutional settings have not occurred with mental health professional intervention but with public interest litigation and Supreme Court directives. A series of public interest litigations starting in 1982 (Veena Sethi vs. State of Bihar) were successful in initiating reform in mental health care. For e.g. in 1983, a public writ petition (Kapur Vs Union of India and others) relating to the poor conditions at the Mental Hospital Shahdara, led to a detailed enquiry through an expert committee appointed by the Supreme Court. The committee's suggestion for change pertained to several areas of hospital functioning from diet, personal hygiene, sanitary conditions to admission / discharge procedures. In May 1989, the Supreme Court decreed that the hospital at Shadara be developed on the lines of the National Institute of Mental Health and Neuro Sciences, Bangalore. This led to the establishment of the Institute of Human Behaviour and Allied Sciences (IHBAS) at Shadara. Similar judgments were passed in response to public interest litigations with respect to Ranchi, Gwalior, Agra and Tezpur.

With regard to the jailing of non-criminal mentally ill, based on a petition by Sheela Barse filed in 1989, the Supreme Court ordered an enquiry into the jailing of non-criminal mentally ill in West Bengal. In 1993, the Court passed a judgment (Sheela Barse vs. Union of India 1993) declaring the practice of housing non-criminally mentally ill persons in jails to be unconstitutional. The court also called for upgradation of mental hospitals in West Bengal.



**Table 2. Public Interest Litigations**

Sl No.	PIL No.	Petitioner	Year	Subject	Observations / Recommendations / Outcome
01		Veena Sethi Vs. State of Bihar	1982	Care of mentally ill persons in institutions	Forerunner to a series of PIL's initiating mental hospital reform
02	OP 7588 of 1986c	Peoples Council for Justice and another Vs. State of Kerala and 3 others	1986	Working of mental hospitals in Kerala	Justice Narendran Commission appointed. Visited hospitals in Trivandrum, Trichur, Kozhikode in 1987
03	WrPet (cri) 237/89	Sheila Barse Vs. Union of India	1989	Jailing of Non-criminal mentally ill persons in West Bengal	Srinivasa Murthy and Amita Dhanda appointed as Commissioners to report on number of mentally ill persons detained in jails, their classification, procedures of admission, care and facilities provided, mental health infrastructure in the State, medical examination and records on patients, staffing patterns, rehabilitation. Guidelines for monitoring the commitment of non-criminal mentally ill persons.  SC ruled that no person should be kept in jail purely on grounds of mental illness.
04	Wr.Pet C No 339 of 1986	Rakesh Chandra Narayan Vs. State of Bihar	1989	Adm. of Ranchi Manasik Arogyashala	Dayal Commission Report (11.7.1994)  Setting up of Adm. of the Ranchi Manasik Arogyashala as an autonomous body.
05	Wr.Pet C No 901 of 1993 and No 80 of 1994	Supreme Court Legal Aid Committee Vs. State of MP and others  Kamini Devi Vs. Union of India	1993  1994	Admn. Control and management of the Gwalior Manasik Arogyashala (GMA)	Setting up of GMA as an autonomous body. Rules for GMA made



06	Cr MP No 505 of 94	S. Muralidhar Vs. others	1994	Rehabilitation of non-criminal lunatics in Assam	<p>Gopal Subramaniam appointed as Commissioner. Order made by Chief Justice of India on 3.10.1994</p> <ul style="list-style-type: none"> <li>• Need for and suggestions pertaining to rehabilitation of NCL's in Assam</li> <li>• Need to compensate those confined in jail in violation of their constitutional rights</li> <li>• Action against authorities and officers of State Govt</li> <li>• Tezpur MH to be made into a Regional Institution of autonomous nature under the NE council (done recently)</li> <li>• Permanent Board of administration to monitor improvement (Took charge in November 1996)</li> <li>• Involvement of NGO's.</li> </ul>
07	OP No 16667	High Court Legal Aid Committee Vs. State of Kerala and SMHA	1996	Mental Hospitals in Kerala	<p>Appointed a panel of advocate commissioners. Order issued on 21.3.1997</p> <p>Committee noted appalling conditions in Mental Hospitals. Made a set of 31 recommendations</p>
08	Wr.Pet C No 448 of 1994	Hingorani Vs. Union of India and others	1994	Admn of Agra Manasik Arogyashala	<p>AMA to be an autonomous institution.</p> <p>Rules of AMA formulated</p>



The Public Interest Litigation thus brought the spotlight on and focused judicial and media attention to the conditions in different mental hospitals.

The atrocious system of keeping the non-criminal lunatics in jail is very well illustrated in the observations made in the Supreme Court Order of 3/10/94 (S. Muralidhar Vs. others in Crl. MP No. 505 of 1994): “The State of Assam has a splendid record of having confined 387 persons to jail only on the grounds that they were mentally ill. In many of the cases, the committee found that they were in fact not mentally ill. In one case a person was confined to jail for merely being talkative”.

Recently, there has been a shift of concern from basic living conditions of the mentally ill to concerns about appropriate treatment. This is illustrated by a public interest litigation concerning the use of Direct Electroconvulsive Therapy. It was filed on behalf of an inpatient who had been administered direct ECT in the High Court of Bombay at Panaji (Civil Writ Petition No.: 257/98), Collasso versus State of Goa and Others. The issues for determination included:

- Whether administration of ECT without anesthesia was barbaric and inhuman and hence in violation of Article 21 of the Constitution.
- Whether administering ECT without anesthesia was in violation of Section 81, Chapter VIII of the Mental Health Act which provides that no mentally ill person shall be subjected during treatment to any indignity (physical or mental) or cruelty.

The Court in its judgement while disposing the petition directed that it was preferable to use modified ECT's under proper supervision unless otherwise indicated.

In summary, the locus of care for the seriously mentally ill began in the lunatic asylums with traditions of care and attitudes of the 18<sup>th</sup> and 19<sup>th</sup> centuries. Even then various reports pointed out the deficiencies of these institutions, low priority accorded to mental health care, violation of human rights of the patients, and the need for development of comprehensive services for the mentally ill. As outlined earlier, there has been a move to develop services more accessible to the community, growth of alternative residential and outpatient settings of care and an increase in the agencies involved in mental health care. There has been a shift worldwide towards catering to mental health needs than just treating mental illnesses. However, despite the emergence of many facilities in the private sector, governmental institutions still continue to render residential care for majority of the seriously mentally ill, especially for the poorer socioeconomic status. These are therefore important institutions wherein to ensure acceptable standards of care. This aspect becomes all the more important if these institutions are to function as an integral and important part of the comprehensive mental health care infrastructure in different parts of the country.



# CHAPTER-6

## AIMS AND OBJECTIVES OF THE PROJECT ON QUALITY ASSURANCE IN MENTAL HEALTH

### Objectives of the Project

1. To analyze the conditions generally prevailing in Government run mental hospitals in various parts of the country, with respect to structural facilities, minimal standards of patient care, facilities available for patients, admission, discharge and appeal procedures, rehabilitation facilities, client satisfaction, staff morale and problems and generate possible solutions for improving standards of care.

2. To enhance the sensitivity of the key administrators from these mental hospitals concerning the running of these institutions.

As an outcome of this, a plan of action would be evolved for improvement of the conditions of the mental hospitals, suggestions made for rehabilitation of recovered patients and enhancement of awareness of the rights of the mentally ill.

### Methodology

The project was planned in 3 phases:-

*Phase I:* A comprehensive assessment of the prevailing conditions of the Government run mental hospitals in India. This was carried out in two stages.

*Stage I* - In the first stage, a proforma was developed by the NIMHANS team for the purpose of collecting relevant information from the various mental hospitals (Appendix 1). This proforma was comprehensive and included information pertaining to both administrative matters and clinical aspects. The proforma was mailed under the aegis of the NHRC to the administrative head of each of the 37 government mental hospitals, with a covering letter which:

- a) explained the project, its purpose and scope
- b) identified NIMHANS as the nodal center and
- c) requested their fullest cooperation

During this stage, the scope of the project was enlarged to include private psychiatric institutions in the country as well as General Hospital Psychiatry Units in Government and Private Medical Colleges. Briefer proformas covering areas of structure, staffing, and services was mailed to these centers. Data from the proforma was subjected to a preliminary qualitative analysis so as to plan inputs for Stage II



*Stage II* - Stage II comprised of onsite visits. Investigators (usually 2) of the project from NIMHANS made field visits to each center and carried out an intensive qualitative evaluation/assessment with regard to quality of care of services provided and issues related to the Mental Health Act 1987 and human rights. The assessment comprised of a physical inspection of the structure and the facilities, including the inpatient services, support services such as kitchen and laundry, outpatient services and so on. Non-participant observation of routine activities was carried out. Interviews with administrators and staff at various levels such as the Administrative Officer, Nursing Supervision, Medical and other staff were held. Patients and relatives were interviewed regarding their perception of the quality of care. Case records, files and other documentation procedures were reviewed. In camera meetings with some of the staff and patients were held.

During the course of visits to the Government Mental Hospitals, the Private Psychiatric institutions and General Hospital Psychiatric Units in the region were visited wherever feasible.

The emphasis was on information gathering in a problem centered and non-inquisitional manner. Audio and video recordings reflecting the state and functioning of each hospital was made, to highlight various aspects of quality care (or the lack of it) and human rights violations. Where interviews of individuals were recorded informed consent was obtained. At the end of each visit, an educational video highlighting the various issues involved in quality care were screened for the staff and patients / families. Emphasis was placed on the therapeutic model of care as against the prevailing custodial model of care, highlighting the fact that, given appropriate inputs, a majority of the mentally ill would be able to return home to their families and carry on their functioning in various roles.

During the visit of the project team, wherever possible, meetings were held with the Chairperson of the State Mental Health Authority and/ or a Senior representative of the State Government. This meeting helped to sensitize the representatives to the various issues of human rights of the mentally ill, to specific problems of the mental hospitals in their state, solutions for the same, and planning of integrated psychiatric services for their state.

During the visits to the mental hospital the project team issued press releases and convened press conferences wherever possible to highlight the various human rights issues of the mentally ill and the purpose of the project.

Zonal meetings were held in Bangalore, Kerala, Agra, Ahmedabad and Calcutta. Non-Governmental organizations, persons suffering from mental illness and caregivers met with the team members to discuss specific lacunae in mental health services and solutions for the same.



### *Phase II: Workshops for selected staff from each hospital*

Phase II comprises of workshops to sensitize and train identified personnel from each hospital. Middle level staff representing different levels such as administration, medical, nursing etc. with a high degree of motivation, and willingness to examine and change the existing situation need to be deputed. The first of a series of 6 day workshops was recently conducted. This workshop was practical skill based and oriented towards generating solutions for problems in Indian hospitals. Educational information was provided in an interactive format with active use of audio visual aids. Background reading material was provided and there was practical exposure to various aspects of administration and clinical care both within the hospital and in the community. A total of 7 workshops are envisaged, with each workshop having approximately 15-20 participants. In all a total of 100 to 125 personnel will undergo training.

### *Phase III: Preparation of the final report.*

This report has been organized in two parts. Part 1 provides an overall comparison of mental health services across psychiatric institutions in the country and the range of services. Part two presents detailed hospital wise reports from each State.



# CHAPTER-7

## RESULTS - GOVERNMENT PSYCHIATRIC FACILITIES

Proformas were returned from all the 37 government psychiatric facilities in the country. 33 of the facilities, except the Institute of Mental Health Care, Purulia, Mental Health Institute, Cuttuck, Hospital for Mental Health, Bhuj, and Mental Hospital, Kohima were personally visited by the members of the NHRC team. The findings presented in this section represent the information provided by the various hospitals and personal observations made by the teams in Government psychiatric facilities. The results are presented largely in the order as in the proforma. Findings relating to private psychiatric institutions and general hospital psychiatric units are provided in separate sections.

### GOVERNMENT PSYCHIATRIC FACILITIES

#### Historical Background

The history of some of the currently existing mental hospitals mirror British colonial approaches and policies towards the care of the mentally ill through mental asylums. A glimpse of the years of establishment of the mental hospitals in India is provided in the introductory chapter in Figure 1. Among the currently existing mental hospitals, the oldest is the Institute of Mental Health, Chennai, the erstwhile Government Mental Hospital, established in 1794. Fourteen other hospitals came into existence in the last (nineteenth) century. Eight were established in the 1900's, prior to independence. Three hospitals (apart from those restructured following public interest litigations) have been established/reconstructed in the last two decades. These include the Mental Hospital, Behrampur and the Institute of Psychiatry and Behavioural Sciences, Altinho, Goa in 1980 and the Purulia Mental Hospital in 1994. However, it must be clarified that the year of establishment refers mostly to the beginning of the psychiatric hospitals as they stand today. The year does not reflect the origin of the psychiatric facility in that region, or the previous institution the hospital replaced. For e.g. although the facility at Altinho, Goa was renamed and restructured in 1980, the mental hospital existed in the present premises since the 1950's and earlier at Chimbel.

Similarly although the National Institute of Mental Health and Neuro Sciences was formally established in 1974, the All India Institute of Mental Health, its predecessor was established in 1954. Prior to this, the Pettah Hospital and the Government Mental Hospital were providing services for the mentally ill since 1848. Further details of the origins of each psychiatric institution are traced in volume II.



In general, psychiatric hospitals in various parts of the country have been rendering services for the severely mentally ill for a mean duration of 85.7 years, ranging from 4 (IMHC, Purulia) to 204 years (IMH, Chennai). While two of the government run mental hospitals are in the heart of the city, a majority (64.7%) are within 1 to 5 kilometres from the city centre, 16.2% between 6 and 10 kilometres from the city centre, and 10.8% greater than 10 kilometres away. Six of the Mental Hospitals are in West Bengal, 4 each in Maharashtra, Uttar Pradesh, Gujarat, 3 in Kerala, 2 each in Karnataka, Bihar, Andhra Pradesh and Madhya Pradesh, and 1 each in Tamil Nadu, Jammu and Kashmir, Punjab, Assam, Nagaland, Goa, and Delhi (refer Appendix 2 for a detailed list of the Government psychiatric hospitals). Thus, it is apparent that these services, which offer majority of the inpatient beds for the care of the mentally ill are disproportionately distributed across different states. The number in each region appear to have no direct bearing on either the population, prevalence of mental illness or the development of ancillary services for the mentally ill in that region. One can at best surmise that the origins of the post-British hospitals have been determined by sensitivity of local administrations to the need for accessible inpatient services in that state or region.

## **The Beginnings**

The origins and early growth of the psychiatric institutions have been influenced by several distinct factors. Some of the institutions were started under the British, e.g. Some of the hospitals in West Bengal under the Calcutta Presidency, the hospitals at Dharwad and institutions in current Maharashtra and Gujarat under the Bombay Presidency. Some were started by considerate Maharajas, who were sensitive to the needs of the mentally ill, for e.g. the predecessor of NIMHANS, the earlier government mental hospital, was started by the Maharajah of Mysore. The Government Mental Health Centre at Thrissur had its origins in the West Fort Hospital for the Insane started by the Maharajah of Cochin as a 2 room hospital, and the hospital in Baroda by Shrimant Gaekwad under Baroda State. These hospitals were subsequently taken over by the State Governments. Some hospitals such as the hospital in Chennai were started by private individuals, usually retired surgeons from the army, and subsequently taken over by the State. Interestingly, the Lumbini Park Mental Hospital in Calcutta was developed by the Indian Psychoanalytical Society in 1940 with 3 beds. This was taken over by the Government of West Bengal in 1984. A few of the hospitals were started exclusively for the European lunatics, distinct from facilities for native Indians, e.g. The European Mental Hospital (now the Central Institute of Psychiatry, Ranchi), and the European Lunatic Asylum, now the Institute of Psychiatry at Calcutta. Some of the hospitals, such as the Mental Health Care Centre in Thiruvananthapuram, Kerala had its origins in a common Hospital for Incurables begun in 1870, and contained a mixture of patients with mental illness, tuberculosis and leprosy. The Calcutta Pavlov Hospital was started in



what was previously a leper hospital known as the Albert Victoria Leper Hospital. The Government of West Bengal took it over in 1960, converted it as the mental hospital in 1966 and renamed it as the Calcutta Pavlov Hospital in 1985. The architecture there is thus over 105 years old. Sharply in contrast are a few psychiatric hospitals which have been actually planned as inpatient psychiatric facilities. Typical examples are the hospital at Jamnagar, rebuilt in 1984, according to a plan of a Swiss hospital, the psychiatric facility at the AIIMH (now NIMHANS, Bangalore), and the new psychiatric hospital being constructed at Bambolim on the outskirts of Panjim in Goa.

Institute of Mental Health Care, Purulia has been a fairly recent addition to the psychiatric hospitals, having been started only in 1994, to house the repatriated patients belonging to West Bengal from the hospital at Ranchi.

### **Administration**

Some of the hospitals were initially administered by the East India Company and subsequently by the Presidencies. Others e.g. Bareilly were initially administered by a Court of Governors. Some of the hospitals were under the control of the prison department at the time of their inception. For e.g. The hospital at Agra was under the control of the Inspector General of Prisons until 1905, the mental hospital at Kohima which was under the prison department until 1975, when it was handed over to the Ministry of Health and Family Welfare. The hospital at Tezpur is under the Home Department of the State. Some of the hospitals have changed many hands. For e.g. the mental hospital at Baroda, initially under the princely state of Baroda came under the administration of the Government of Bombay following independence. In May 1960, it came under the administration of the Government of Gujarat. Monitoring of services in some of the state run mental hospitals has been more rigorous only after the public interest litigations and appointment of special commissions of enquiry by the Supreme Court or State High Courts

### **Growth and utilisation of services**

Some hospitals started as very small units, e.g. Bhuj which was established as a 16 bedded hospital, Lumbini Park Hospital, with 3 beds initially, or the Thrissur hospital with initially only 2 rooms. Most hospitals have increased their intake considerably. Despite the large number of allotted beds, overcrowding has been a constant problem in some hospitals. Yeravada Regional Mental Hospital (now the Regional Mental Hospital, Pune) started with 700 patients initially. This number gradually increased to 1200, and then to 1700. It finally jumped to 2540 patients. On the other hand, IHBAS at Shahdara has actually been able to reduce its bed strength. The overcrowding is because some of the hospitals cater to a variety of populations and large geographical areas in the absence of smaller more accessible services. For



e.g. At one time the Ranchi Institute of Neuro Psychiatry and Allied Sciences (RINPAS) catered to patients from all of Eastern India, Bihar, West Bengal, Orissa, Manipur and Mizoram. The hospital in Chennai is the only refuge for poor patients from all over the state of Tamil Nadu. There are no separate inpatient facilities in Haryana and patients are dumped in faraway Amritsar Mental Hospital.

### **Strange Shifts and State Shifts**

Three of the hospitals in the country had strange shifts. The Dr Vidyasagar Government Mental Hospital at Amritsar was established in 1950, following the partition of India. At this time all the Hindus and Sikh inmates of the Lahore Mental Hospital were shifted by a special train to the Ranchi Asylum and then to Amritsar. They were housed initially in a subjail/reformatory for criminal tribes with a bed strength of 50, on a 26 acre ground outside the city. Similarly, the Yeravada Regional Mental Hospital was first situated at Colaba in Mumbai (1907) and shifted to Yeravada in Pune in 1915. A special train carrying the inmates, staff and materials was used to shift to Pune.

The Mental Hospital at Tezpur was originally in Dacca. In 1876, two years after the reorganisation of the Assam province, the hospital was transferred from Dacca to Tezpur and started with 24 patients. A fire destroyed the hospital in 1898, and the present building was constructed in 1932.

The Nagpur Mental Hospital was originally located in Jabalpur, which was part of Madhya Pradesh. It shifted to Nagpur as part of the Central Provinces. This later came under Maharashtra State. Similarly, in Ahmedabad, which was earlier part of Greater Bombay, a new hospital was constructed. However, following the reorganisation of states, the hospital was taken over by the State Secretariat. Ironically, the road still continues to be called the Mental Hospital Road. The Institute of Mental Health (IMH) Hyderabad was originally situated at Jalna, which was part of the Nizam's Government in the present state of Maharashtra. After change in the state policy in 1907, the hospital was shifted to Hyderabad in 1908.

### **Conclusion**

In summary, the origins of the psychiatric hospitals have greatly influenced their current functioning. They have either remained totally unchanged or retained vestiges of more than one or two centuries. Buildings, as well as practices and nomenclatures of those times persist. Many of the hospitals have undergone several rechristenings, usually from the Lunatic Asylum, to a Mental Hospital, to a Psychiatric Institute. The Central Institute of Psychiatry (CIP) Ranchi is the result of four such rechristenings. To what extent the change in nomenclature has resulted in structural and functional improvements in the various hospitals is discussed in the chapters that follow.



## **Hospital Infrastructure**

Fourteen (37.8%) of the hospitals still retain the jail like structure they had at the time of inception. A classical example is the Mental Hospital Behrampur in Murshidabad (hereafter referred to as MH Murshidabad) which was originally a special jail (Netaji Subhash Chandra Bose was imprisoned here). This jail was converted into a Mental Hospital in June 1980, without any major change in structure. It is still surrounded by watch towers. Thirteen other hospitals similarly retain their original custodial appearance. In fact, at the hospital in Varanasi, just as in jails, a register of all visitors is kept.

The IMH Hyderabad has a different story to tell. As mentioned earlier, this hospital was shifted from Jalna to Hyderabad. The site chosen for the hospital had previously been leased out to the Royal Air Force. In 1948, the land was given to the State of Hyderabad (now Andhra Pradesh). Part of the land belonged to 13 different owners, who were paid a paltry compensation of Rs. 200 per acre (this property is under litigation). Remnants of the RAF are still visible at the IMH, Hyderabad. The small hangars are being utilized as wards, and the barracks as staff quarters.

Nine of the hospitals constructed before 1900 have a custodial type of architecture, compared to 4 built during pre-independence and one post independence. Although it is reassuring that the more recent hospitals are more therapeutic, it remains a major concern that the older hospitals remain custodial in structure and function, more than hundred years later.

## **High Walls**

Twenty one (56.8%) have high walls. This includes 12 (44%) of the pre - 1900 hospitals, 5 (18.5%) and 4 (14.8%) established after 1947. Seven hospitals, though they are more like hospitals than jails in appearance, still have high walls. The high walls stamp a label of custodial care and increase stigmatisation. That they do not always provide the perceived “security” is amply illustrated by the discovery of a pregnancy only after delivery in the hospital at Amritsar.

## **Nomenclature**

Although many of the hospitals as mentioned earlier have changed many names and evolved from ‘lunatic asylums’ to institutions of ‘Mental Health Care’ or ‘Institutes of Mental Health’, many of the practices of custodial care are prevalent to date. One outstanding example is the terminology used in many of the hospitals, for e.g. in Tamil Nadu, West Bengal, Maharashtra, Kerala, etc. Patients are referred to as ‘inmates’ and persons in whose care the patients remain through most part of the day are referred to as ‘warders’, and their supervisors as ‘overseers’. Different wards are referred to as ‘enclosures’. These are still existing legacies of the out moded



practices of custodial care. Such findings reveal more than a problem of semantics. They are reflective of attitudes towards the mentally ill and highlight the need to look beyond just changing names of the institutions of mental health care in the country.

## **Acreage**

Most mental hospitals vary greatly in their land area. While 9 (24.3%) are situated in an area less than 5 acres, 21 (66.7%) are located in an area between 10 to 100 acres. Five hospitals (13.5%) have a sprawling campus ranging between 55 to 500 acres. These include IHBAS, GMHC Thrissur, RINPAS and NIMHANS (only a part is for psychiatric services). Hospitals built prior to 1900 have a mean acreage of 60.5 (SD 64.6) acres. Hospitals built between 1900-1947 (pre independence) have a mean of 138 (SD 197.6) acres and hospitals constructed post independence have 33.3 (SD 46.1) acres. These differences, however, do not reach statistical significance.

## **Garden and compound**

As is evident above, most hospitals have plenty of space around them, varying from a few to hundreds of acres. However, the space around the hospitals (either gardens or open space), was well maintained in 19 (54%) of the hospitals visited. Sixteen (45.7%) of the facilities had very poorly maintained facilities. This was not entirely determined by the size of the hospital property. For e.g. The Central Institute of Psychiatry, Ranchi, despite being located in a sprawling compound has well maintained gardens, with solar heaters and pumps. A separate horticultural officer supervises this. The gardens at the Gopinath Bordoloi Institute at Tezpur are also well maintained. There are many deer on the campus, tended for by the patients and staff. The Mental Hospital Bareilly, has an excellent garden, maintained by the patients themselves. On the contrary, in some places, despite the relatively smaller space, the space around is completely neglected, e.g. in the Mental Hospital, Varanasi, Gwalior Manasik Arogyashala (GMA), IMH Vishakapatnam and the hospital at Amritsar. In the hospital at Indore, pigs and cats roaming around the hospital site is a common sight.

Encroachment is yet another problem in many hospitals, e.g. Dr. Vidyasagar Government Mental Hospital (VGMH) Amritsar, MH Indore and NIMHANS.

## **Approach**

Approach to the hospital is adequate except in four hospitals, Mental Hospital Indore, where the front is completely encroached, Vidyasagar Government Mental Hospital Amritsar, HMH Ahmedabad and in Mental Hospital Calcutta and Mankundu. The Lumbini Park Hospital in Calcutta opens straight onto the main road. Approaches



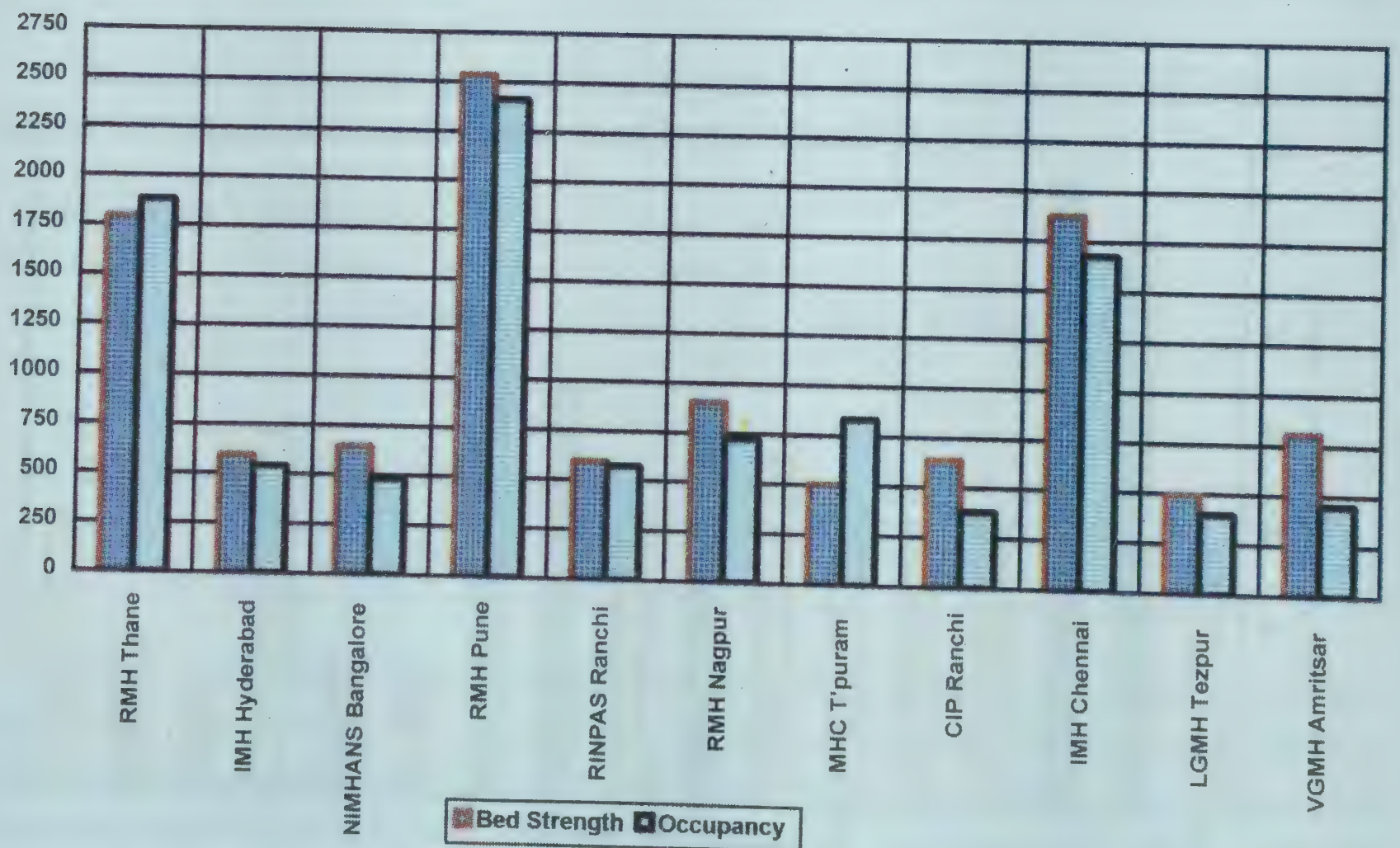
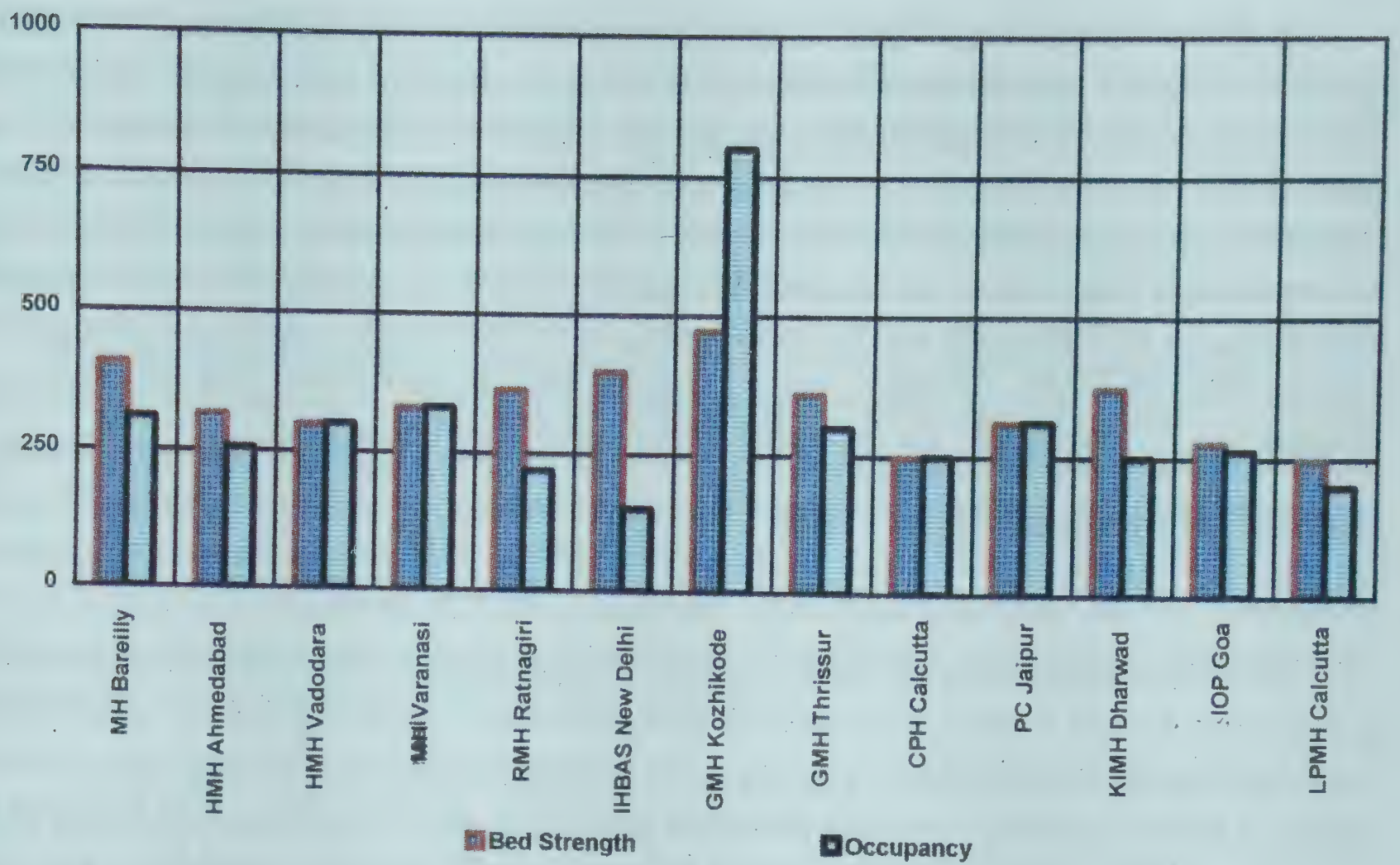
between one section of the hospital and the other was very poor in 3 of the 35 hospitals visited, namely Government Hospital for Mental Care, Vishakapatnam, and the hospitals in Indore and Amritsar. In the hospital at Amritsar, the pathways between the wards are so poor, that trolleys or wheelchairs cannot even be pushed along and patients have to be carried from ward to ward, e.g. after electroconvulsive treatment therapy . However, lighting in the paths connecting one ward to another is extremely inadequate in many of the hospitals. The additional problem of overgrown bushes and grass, and the risk of snakes makes travelling from ward to ward very difficult especially at night. This is a further disincentive for the attenders and staff to take regular rounds through each ward.

**Bed Strength and Occupancy**

The overall bed strength of all the 37 hospitals is 18,024, with a mean of 440.6 (Range 16 to 2540). Bed strength and occupancy were calculated across small (below 250), medium (250 to 500) and large (greater than 500). This is shown in the accompanying Figures 2, 3 and 4. In small hospitals, except in HMM, Bhuj, no overcrowding was noticed. Among medium sized hospitals, overcrowding was evident in GMH Kozhikode, where there is more than 200% overcrowding. Overcrowding in large mental hospitals was evident in MHC, Thiruvananthapuram and in RMH, Thane. These findings are reminiscent of Mapother’s observations of 29% overcrowding at Yeravada and 93% at Chennai in 1938. Low patient turnover and accumulation of chronic patients, coupled with inadequate efforts at discharge and after-care contribute to the overcrowding.









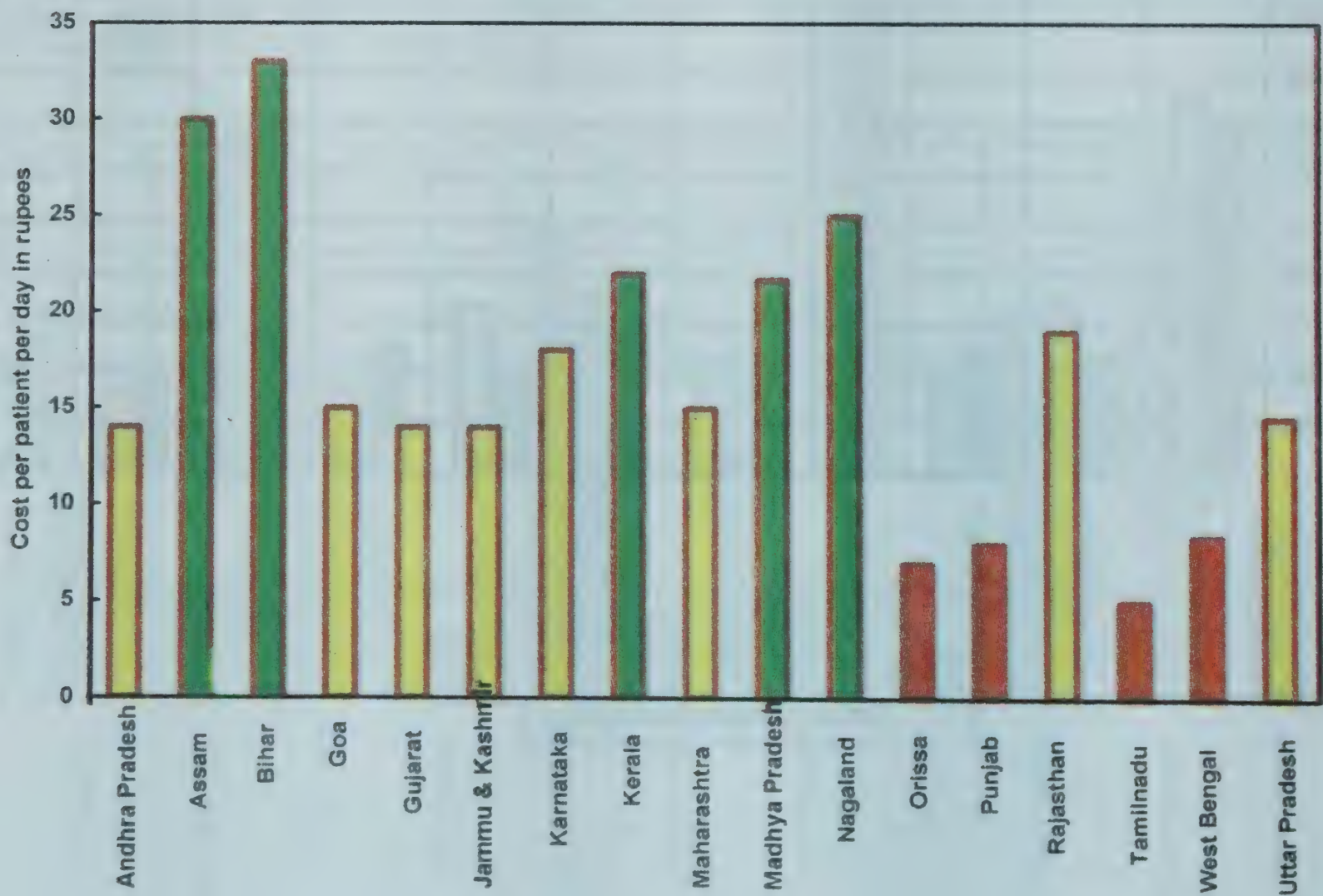
In the sections that follow the adequacy of amenities for patients, from basic needs to range of services are discussed. It must be clarified here that when certain facilities are rated inadequate, they are usually abysmal. The rating of adequacy has been fairly liberal. Thus the findings probably present a rosier picture of what is reasonably adequate, and a less bleak view of the inadequacies. Comparisons, wherever possible have been made on 4 parameters, namely, years of establishment, statewise, by bed strength and by monitored status (hospitals under monitoring following PILs at Delhi, Gwalior, Agra, Tezpur, Ranchi and Pune) and autonomous institutions (NIMHANS) are included under ‘monitored hospitals’.

## BASIC LIVING FACILITIES

### Diet

Quality and quantity of food served to the patients is one of the most variable parameters across mental hospitals. In IMH Chennai, general patients are given a food budget of a paltry Rs. 5 per day. The Superintendent’s efforts to turn out as much of a nutritious and variable diet as is possible is commendable. The hospital at Cuttuck and the VGMH Amritsar are in a similar situation at Rs. 7 and Rs. 8 per day respectively. Although this had been increased to Rs. 25 at the time of the team’s

**Figure: 5- Expenditure on food per patient per day (Statewise)**





visit, the increase had not occurred due to irregular funding. Expenditure on diet in Assam and Bihar is the highest, over Rs. 30 per day. The statewise cost of spending on diet is indicated in the accompanying figure and the inequities are self evident. Cost per day does not differ significantly across small, medium and large size hospitals. Monitored hospitals spend a mean of Rs. 20.8 on food compared to non monitored hospitals which spend Rs 17.5 per day (differences not statistically significant).

Few hospitals appear to calculate the calories being provided. In the 20 hospitals where information is provided, calories provided range from 1200 to 3322 calories. As most of the hospitals providing over 2800 calories are being monitored, it would be erroneous to provide an overall mean of the cost of diet. Another incorrect assumption would be that the quality of the food is good wherever the cost is relatively higher. The hospital at Vishakapatnam illustrates this. Although a considerable amount is spent on each patients diet, the diet services are contracted out, and the quality of the food provided is substandard.

In many places, patients complained that all the food was just lumped together. This was resented. Serving the food with some care and adequate courtesy should go hand in hand with quality, nutritious food. The other aspects of diet, including the pantry and food distribution are discussed under Supportive Services.

**Cots**

The ratios of cots, toilets and fans to patients were compared to provide some idea of the extent of amenities provided in the Mental Hospitals

**Table 3. Cot : patients**

Established	Cot : Patient Ratio
Before 1900	1 : 1.5
Pre-independence	1 : 1.4
Post-independence	1 : 1.3

The overall ratio of cots: patient is 1:1.4 indicating that floor beds are a common occurrence in many hospitals. This is further borne out by the overcrowding that is present in some hospitals. Such a low patient: cot ratio is not just a feature of hospitals established pre 1900, but are present even in more recent times. Even in hospitals which indicated patient : cot ratios as 1:1, many of the cots had been sent for repair, leading patients to sleep on cold, damp floors. When monitoring status was considered, monitored hospitals had a bed ratio of 1:1 compared to non-monitored hospitals, where the ratio was 1:1.4. Patient: cot ratio did not differ significantly across small, medium and large hospitals.



# TOILETS

Table 4. Toilet : patients

Established	Toilet : Patient Ratio
Before 1900	1 : 16
Pre-independence	1 : 7
Post-independence	1 : 5

In the hospitals at Varanasi, Indore, Murshidabad and Ahmedabad (male wards), patients are expected to urinate and defecate into an open drain in public view. These drains are often cleaned just once a day,. The toilets in many of the hospitals are badly clogged and choked with faeces. There are no taps in the toilets in some hospitals, e.g. KIMH, Dharwad. Thirteen (35%) hospitals had very dirty toilets. This was especially a problem in places with poor toilet : patient ratio, and where there was no running water.

Some degree of privacy is offered by hospitals established post-independence (11) (31.4%). Lack of privacy is greatest in the older hospitals (pre 1900). The differences across the groups is statistically significant (DF 2, likelihood ratio significant at 0.03).

# FANS

Table 5. Fans : patients

Established	Fan : Patient Ratio
Before 1900	1 : 9
Pre-independence	1 : 8
Post-independence	1 : 9

Fans are provided in most hospitals, but are inadequate in some, e.g. KIMH, Dharwad, GMHC, Thrissur, IMH, Hyderabad, IMH Chennai, MH Mankundu. Monitored hospitals have a better fan : patient ratio (1:5) compared to non-monitored hospitals (1:12). A common concern for non provision of fans is the concern of suicidal attempts. The experience at NIMHANS suggests that as long as monitoring of patients in the ward is adequate, this is not a problem. Many of the cold places have no heating facilities, and patients are often found lying with scanty clothing directly on the cold floor.



## **Water Supply**

Many hospitals have problems with running water. This often reflects the water scarcity in the State. However, storage facilities are also poor in 26 (70.2%) hospitals. This leads to a shortage of water. Patients sometimes have to go out of the ward to get water.

Safe, drinking water is not easily available in some hospitals. A common bucket is placed outside the ward. Patients have to reach out through the bars (during the night, where they are locked up) in many hospitals, scoop out water to drink from a common mug. This is not only a deplorable practice, but is an open invitation to spread of infections, especially gastrointestinal endemics. The lack of drinking water must be immediately rectified.

Some of the hospitals do not provide hot water for bathing, even during winter. Open baths are a common feature, e.g. In Varanasi and Amritsar.

## **Electricity**

Electrical supply is adequate in 27 hospitals (73%). It is erratic at the hospitals in Indore, Agra, all of Bihar, Vishakapatnam and some of the hospitals in Calcutta. This is partly reflective of the power situation in the states. Many of the hospitals do not have generators.

## **Lighting**

Lighting is inadequate in 14 (37.8%) of the hospitals. This is especially a problem in the campus area. The poor light makes it very difficult to go from ward to ward. Cases of assault, robbery and rape were reported from some hospitals with poor lighting. Such incidents were attribute to poor lighting and poor security in the campus.

## **TYPE OF WARDS**

### **Closed Wards**

Thirty-three (89.2%) had closed wards. Nineteen (51.3%) had exclusively closed wards. The number of closed wards ranged from 1 to 6.

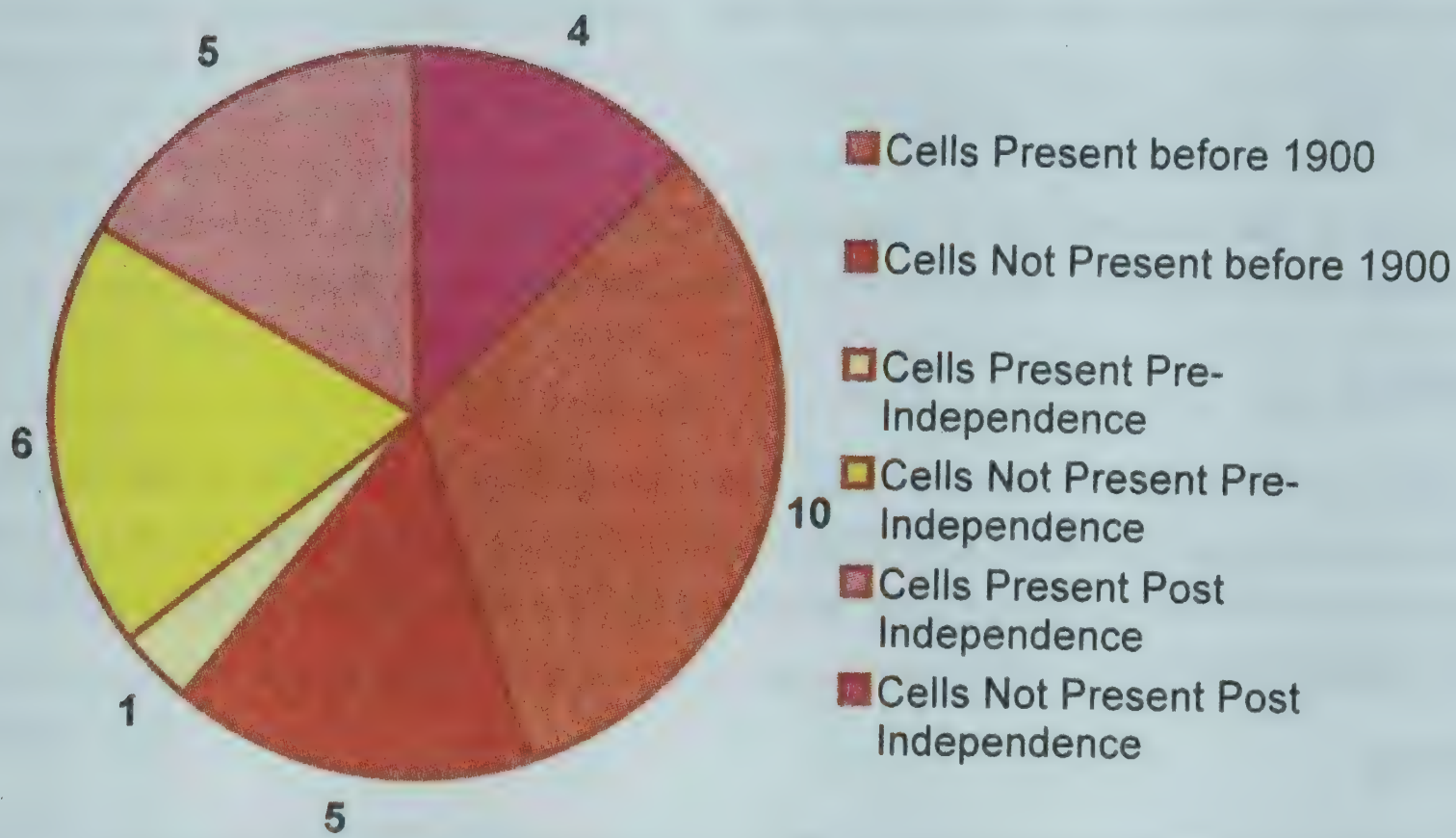
### **Cells**

The accompanying pie chart provides a shocking revelation that 16 ( 43.2 %) of the 37 hospitals have cells. Cells were much more likely to be present in hospitals pre-1900. However, even among hospitals established post independence, more than half (5 out of 9) still use cells. In some places, many patients are dumped into one cell. In other hospitals single cells are used. Many single cells do not have any water,



linen, beds or toilets. Patients remain locked in all the time. They have to urinate and defecate in the cell itself.

**Figure 7. Presence of Cells**



When the monitored and nonmonitored hospitals were compared, it emerged that cells are used in only one of the 7 monitored hospitals in contrast to 15 of the 30(50%) of nonmonitored hospitals.

**Open and Paying Wards**

Open wards, ranging from 1 to 13 were present in 20 (54%) hospitals. Only 16 (43.2%) had provision for paying wards.

**Children’s Wards**

Separate facilities for children were present in just 4 (10.8%) hospitals. In some hospitals, such as in Yeravada and Vishakapattanam, children were being admitted under the Indian Lunacy Act, 1912 into the closed wards (eg. In Yeravada and Vishakapatnam). This is in gross violation of the Mental Health Act.



## **Criminal Wards**

Criminal inpatients are being admitted in 20 (54.1%) of the hospitals, but a separate facility for the criminally mentally ill was present in only 15 centers. In such centers, the movement of all other patients is also grossly restricted. Many of the criminal wards are worse off than the other wards in terms of being totally isolated (e.g. in IOB Goa) and having poor infrastructural facilities when compared even to jails.

## **De-Addiction Wards**

De-Addiction as a specialty has been receiving a little more attention in recent times, probably because of more avenues of funding in this area. Twelve (32.4%) of the facilities had separate De-Addiction wards. During the team's visits, such facilities were under construction at the hospitals in Ranchi (CIP), and Tezpur. The hospital at Cuttack is also under the process of establishing such a ward, according to the proforma.

## **Family Wards**

The concept of a Family Psychiatry ward is misunderstood in many places for an open ward where families are allowed to stay. Family psychiatry refers to evaluation and management of family issues that may lead to or modify psychological or psychiatric illness. Such facilities were present in only 5 (13.5%) of the hospitals.

## **Chronic patients**

Large institutions, inadequate psychosocial interventions, long distances and unavailable families all perpetuate chronicity. This is evident in the number of chronic patients in many of the hospitals. Mean number of patients remaining in the hospital for over 2 years was 172 (SD 268), ranging from 0 to 1409. When chronicity was compared statewise, the accompanying table reveals that there were significant differences across States (F ratio 2.8, F probability 0.02). Patients remaining in the hospital for over 2 years was greatest in Maharashtra (624.8), followed by Tamil Nadu (616).



**Table 6. Mean No. of Chronic Patients Statewise (hospitals where data is available)**

State	No. of Hospitals	Mean No. of Chronic Patients	Standard Deviation
01. Andhra Pradesh	2	44.5	44.5
02. Assam	1	70	-
03. Bihar	2	244	96.2
04. Delhi	1	44	-
05. Goa	1	47	-
06. Gujarat	4	94.8	-
07. Jammu & Kashmir	1	1	-
08. Karnataka	2	107	11.3
09. Kerala	2	152	121.6
10. Maharashtra	3	624.8	529
11 Madhya Pradesh	3	102	57.2
12. Nagaland	1	3	-
13. Orissa	NA	NA	NA
14. Punjab	1	194	-
15. Rajasthan	1	57	-
16. Tamil Nadu	1	616	-
17. West Bengal	5	46	65.6
18. Uttar Pradesh	2	153	25.4



**Table 7. Break-up of Chronic Patients**

<b>Duration of stay in Hospital</b>	<b>Males</b>	<b>Females</b>
< 1 year	00.00	40.30
1 – 2 yrs	33.70	22.30
2 – 3 yrs	21.40	17.00
5 – 10 yrs	30.60	25.50
10 – 15 yrs	17.5	17.70
> 15 yrs	27.00	23.00

As shown in the accompanying table, most of the patients stay for less than 1 year. Long stay patients, staying over one year are generally less for both male and female patients. From the above table, it is evident that although females appear less in absolute numbers, a greater proportion of women remain longer compared to men e.g. In Jaipur, the number of longer stay patients are more likely to be females, suggesting greater discharge problems. There are also repeat admissions and the common reasons given are poor drug compliance or poor family support. The reasons given for problems with discharge of patients is lack of interest of family in the patient, house addresses not being traceable and relatives abandoning patients.

Other aspects of inpatient services are dealt with in the next section.

## **SUPPORTIVE SERVICES**

### **Dietary and Pantry Services**

The cost of diet has already been discussed. Timings of serving the diet also vary across hospitals. Breakfast is served between 6 am to 8.30 am across different hospitals. Lunch varies between 11 am to 1 pm. Dinner varies between 5 to 7 pm. Many hospitals serve only 3 meals, and dinner is often completed by dusk. Patients have virtually nothing to eat for more than 13 to 14 hours. This undesirable practice may actually worsen their irritability and lead to more problems in management.

In most hospitals, the Medical Superintendents, RMO's or Nursing Superintendents are incharge of the diet. A few hospitals have kitchen supervisors. 11 hospitals (29.7%) have dieticians or assistant dieticians. Food supplied on contract is not found to be a satisfactory practice as it is virtually impossible to plan individual diets, and monitor quality on a regular basis.



## Other Supportive Services

Canteen facilities are adequate in 14(37.8%). Telephone facilities are provided in only 20 hospitals (54%). Library facilities for patients are present in 27 (72.9%). Twenty-six hospitals (70.3%) have library facilities for staff and trainees.

Recreational and religious activities are present in 25 (67.36%) hospitals.

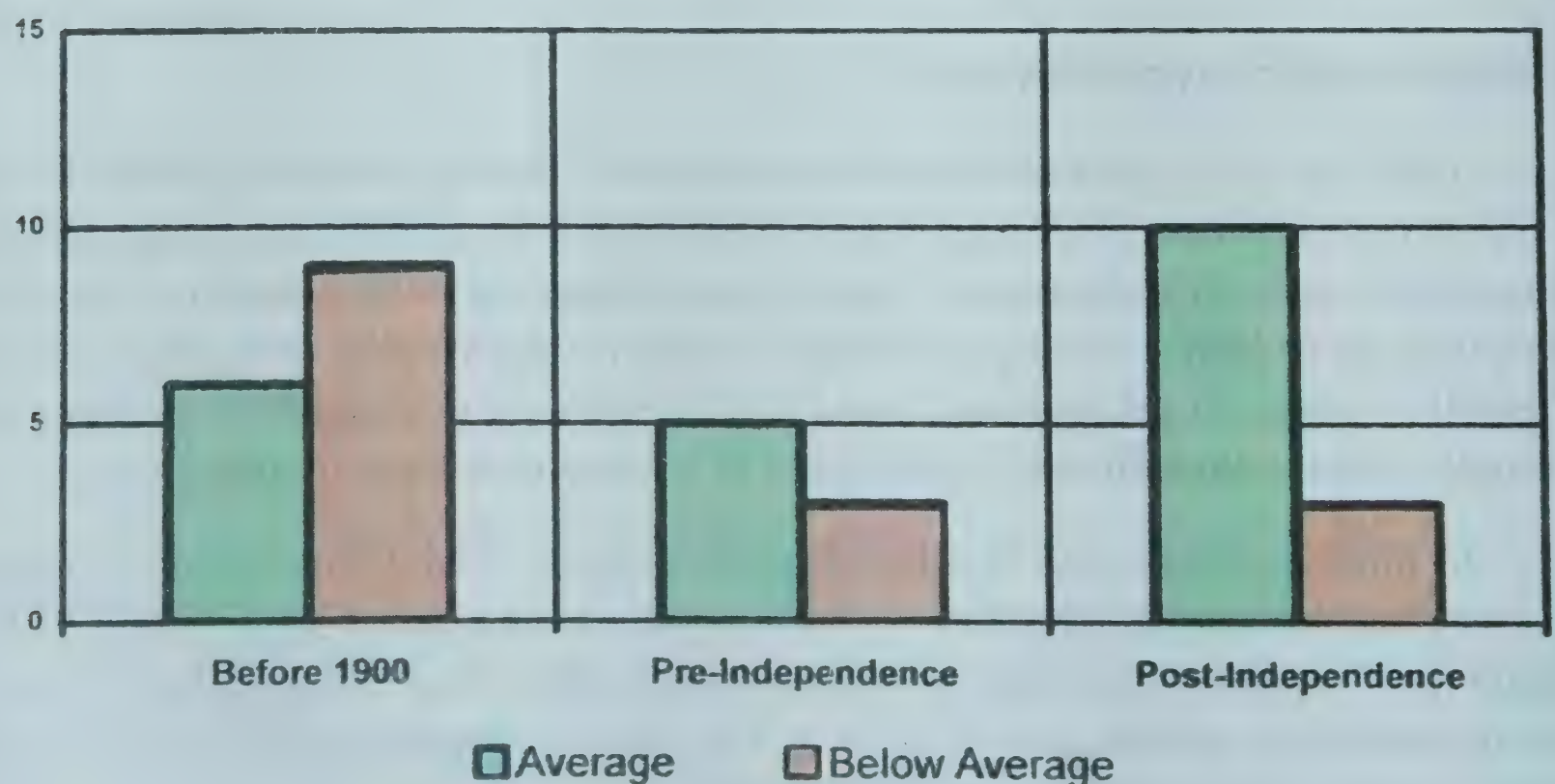
## Medical Records

Among the 37 hospitals, 33 (89%) have separate case files maintained for each patient. Time for retrieving case files ranged from 1 to 90 minutes. The staff working in the records section range from 2 to 28. This is further discussed in the section on staff patterns. In some hospitals, different inpatient and outpatient files are maintained for the same patient leading to much confusion.

## Overall Maintenance

Most hospital buildings are maintained by the Public Works Department (86.5%) and some by the Directorate of Health (8%). Very few hospitals, e.g. NIMHANS have full time staff on the campus for maintenance. While maintenance is reasonable in 21 (56.7%) it is extremely inadequate in 26 (70.3%) hospitals (Figure 8). Leaking roofs, overflowing toilets, eroded floors, broken doors and windows are common sights. The hospital at Murshidabad deserves a special mention here. The walls are covered with lice, and the unsanitary surroundings have ensured that practically all the inpatients suffer from lice infection and scabies. Conditions are very poor also at Indore, Varanasi, Amritsar and Vishakapatnam.

**Figure 8. Level of Maintenance of Hospitals**





Maintenance has definitely improved in the hospitals that have some kind of monitoring.

## **Conclusion**

There are glaring deficiencies in hospital infrastructure and basic amenities like cots, quality food and toilets. The findings of Mapother and Taylor still ring true after almost 50- 60 years. It is almost as if time has stood still in many of the mental hospitals. More changes have been brought about in jails through prison reform than in mental hospitals.

A ray of hope is the visible change occurring in monitored hospitals. In the rest, the situation needs to be immediately remedied. Specific suggestions to rectify the same are discussed in the section on recommendations.

## **PSYCHIATRIC SERVICES**

### **Introduction**

This section examines the clinical services offered to the consumers, that is, people who present to hospital with mental illness. These services include inpatient facilities, and cover admission and discharge procedures, medical record keeping, Board of Visitors and Management and the rights of patients in different psychiatric hospitals. Casualty and emergency services, outpatient services, investigation and treatment methods available across hospitals are also reviewed. These clinical services are the most crucial for the client who needs help. However it is unfortunate that they are among the poorest in terms of adequacy and quality. It is possible that this area gets neglected in our system, as the consumers are not in a state to demand their rights to appropriate facilities. Others like the mental health staff need to be their advocates to ensure quality services. The following analysis is based on the data provided by the 37 Government hospitals, but it is not entirely complete in all the areas.

### **Admission and Discharge**

Twenty-six hospitals (70.3%) reported that admissions are governed by the Mental Health Act, 1987. Two hospitals (5.4%), still use the Indian Lunacy Act, 1912 and 7 (19%) hospitals use both these acts. This indicates a glaring lack of awareness on the part of the judiciary since the ILA has been repealed. Although most hospitals reported that they follow the Mental Health Act, the fact that many of them still use the Board of Visitors for Decertification suggests that the Act is not being followed in entirety in most places.

The admitting authority in most cases is the psychiatrist or the judiciary. The provision under 'Admission under Special Circumstances' (e.g. by the police, rela-



tives or friends) is rarely utilized. This trend possibly reflects the lack of knowledge and awareness about these sections of the Act in terms of provision for easy admission. Thus the whole idea of simplifying admissions under the Mental Health Act is not reflected. Hospitals in West Bengal have to have each of their admissions ratified by the Directorate of Health Services. Mental Hospital, Indore has only involuntary admissions. Ironically, Court admissions are easier in the hospitals at Maharashtra. Families prefer to get their wards admitted through courts because in some hospitals, voluntary admissions are charged, unlike court admissions. The Mental Health Act forbids children to be admitted in mental hospitals, but some hospitals had admitted children under the Indian Lunacy Act and the Children's Act (e.g. in Pune, Vishakapatnam). Children should be admitted to juvenile homes and reception centers monitored by the Welfare Department of the State. The facilities and care provided at such centers is another great issue of concern.

Twenty six (70.3%) of the 37 hospitals said they explained the rights of patients on admission and it was reported that the patients had a Right to Appeal in 35 centers (94.6%). However, during the field visits the project team observed that this was not being actually practiced. Patients were not even aware of this fact in all the hospitals.

## **Voluntary Admissions**

Although there are many involuntary admissions in mental hospitals, it is heartening to note that voluntary admissions have been steadily increasing as was evident over the five years under review (1992-1996). In some hospitals, at discharge, the involuntary patients are decertified by the hospital authorities and sent home with relatives, hospital escorts or alone. This data further highlights the fact that the Mental Health Act has made the process of admission and discharge much easier, but needs to be utilized better in all hospitals. More professionals and the judiciary need to be educated about the Act and all its provisions, as the legal aspects are not universally known by all concerned.

## **Mortality**

The mortality figures available for the last five years also shows that the number of deaths have decreased over the years and deaths due to suicide have ranged only from 1-5 deaths per year. Most of the hospitals did not report homicides and a few reported one in the past five years. Escapes from mental hospitals were described in earlier literature as a common phenomenon in closed wards. If the Act is truly implemented there should be no need for any patient to "escape". This term should then have use only for patients who are involuntarily confined. The data collected in this study shows that the number of patients who "escape" ranged widely in the hospitals from nil to 300 escapes per year (MHC Thiruvananthapuram). The phe-



nomena of suicides, violence and homicides, and escapes appear common when conditions in the closed wards are intolerable due to overcrowding, poor living conditions, inadequate drug treatment and poor staff supervision and monitoring.

## **Inpatient Services**

The wards of a psychiatric hospital are the milieu in which the mentally ill are treated so that they may make an adequate recovery to face the outside world. Hence a good hospital must have a conducive environment with an active program and humane staff. There was at least some skeletal daily ward routines in 33 (89.2%) hospitals. Thirty (81.1%) hospitals reported that wards were cleaned daily and patients given a bath daily. The dresses of patients were changed once in 2-3 days in 22 hospitals (59.5%) and linen changed once in 2-3 days in 12 hospitals (32.4%), and once a week in 18 hospitals (48.6%). In the remaining hospitals the change of clothes and linen was even less frequent. The reason for this infrequent change was a lack of available uniforms. The plinth area of living space in the wards for each patient varied very widely for each hospital as did the availability of cots, mattresses, linen, blankets, warm clothes, uniforms and toilets per patient. Patients were allowed to wear their own clothes in 27 (73%) hospitals. There were specific uniforms provided for males and females in 28 (76%) hospitals. The basic facilities in the wards such as cots, toilets, and fans have already been discussed in pages 42 and 43.

Privacy for patients in wards was present in less than half the hospitals (41%) and facilities for keeping patients' belongings like lockers and cupboards were present in 21 (56.7%) hospitals. Some basic recreational facilities in the wards like television, radio, indoor games, newspapers were available in 31 (83.7%) hospitals.

Records were maintained by the ward staff of vital parameters like menstruation in 25 (67.6%) and body weight in 27 (73%) but this was not routine in most hospitals. Shaving of the head for lice infestation and hygiene was rather routine for males in 26 (70%) and in females in 17 (46%) of the hospitals. The barber is available for hair cut and shaving of beard in 35 (95%) hospitals though the frequency varied (haircut monthly in 20 and shaving once a week in 18). Inpatient emergency services were present in 33 (89.2%) hospitals. Antilice and bug measures were adopted in 33 (89.2%) hospitals but were not effective in most due to the low frequency of application (i.e. quarterly in 26 (70.3%) hospitals and less frequent in others). Anti mosquito measures, mainly as repellants were employed in 28 (75.7%) hospitals. Seclusion rooms are present in 28 (75.7%) hospitals and are used in 26 of these hospitals reportedly for violence or new admissions. Duty rooms for doctors and nursing stations are present in 30 (81%) of hospitals. Only 14% of the respondents felt that their hospital inpatient facilities were adequate. This dissatisfaction with facilities reflects the non-conducive ward environment in many of our hospitals. In about a third of the Government hospitals the ward conditions are pathetic



and subhuman due to overcrowding, poor upkeep of the facilities, financial constraints and apathy of the staff and professionals. In some hospitals, e.g. the hospital at Murshidabad, doctors do not visit the wards regularly, because of fear of infestation from lice and scabies.

In most hospitals, case file recording is extremely inadequate, and “repeat all”, without any documentation of the mental or physical status, is a common occurrence.

### **Board of Visitors / Management**

Board of Visitors (BOV) or Management is present in 23 hospitals (62.2%). Where present, the Board was constituted as per the MHA, 1987 and functioned as per the rules laid out in the Act. While the Mental Health Act removes the powers of decertification from the Board, a Board is required for regular inspection and monitoring.. The BOV met monthly in only 12 hospitals and less frequently in 6 hospitals. However, under the MHA, the Board is expected to inspect at least once a month. A book is required to be maintained to enter the observation and remarks of the BOV regarding the state of affairs of the hospital and details of admissions made during the previous month. Admission with legal procedures is common in only 6 hospitals. In such hospitals, more than 90% of their admissions are with legal procedures. In other hospitals the procedure is used in less than 10% of admissions. The MHA, 1987 is fully complied with in only 19 (51.4%) hospitals and it is partially complied with in 15 (40.5%) hospitals. The lack of awareness of the legal aspects and non-compliance with current laws of the land necessitates workshops to improve awareness and compliance of the Act. In some of the hospitals there have been legal complaints about the conditions of patients and also public interest litigations. These details have been discussed in the introductory chapter.

### **Staffing**

Details of staffing are discussed in the next section. What needs to be highlighted is the lack of staff, especially trained paraprofessionals. Less than half the hospitals have clinical psychologists and psychiatric social workers. Wherever they are present, they appear to be more involved in tasks of a clerical nature, rather than provide specialized inputs for the patients. Trained psychiatric nurses are present in less than 25% of the hospitals. Lack of these staff means that hands are not available for multidisciplinary work with patients. There are laboratory technicians only in a handful of hospitals but ward attenders and peons are present in larger members in most of the hospitals, sometimes even exceeding the total number of patients, as was the case in some of the hospitals in West Bengal. Unfortunately many of these group D workers are not engaged in patient care either due to lack of training or motivation. In some hospitals the judiciary have passed strictures on them due to ill



treatment, neglect of patients or due to corrupt practices. Further issues related to staff are discussed later.

## **Investigation and Treatment Facilities**

It is rather upsetting to note that even routine blood and urine tests are not available in more than 20% of the hospitals, even for inpatients. Other investigations such as VDRL, serum lithium estimation, x-ray, EEG, HIV screening, Hepatitis B screenings are available in different hospitals depending on their resources and sophistication. They are present in less than 30% of hospitals. Even then the routine tests are not available through 24 hours. These tests are no longer considered specialized but are needed to make crucial decisions in treatment.

On the other hand psychosocial investigation facilities are available in even fewer places, even where psychologists or psychiatric social workers are present. The reason for this deficiency is not just the lack of trained professionals but also because of a lack of awareness of the multidisciplinary approach and absence of role clarity and functions. Psychological evaluations are crucial in evaluating mental functions, diagnostics and for purposes of certification for legal purposes. The absence of these tests is a handicap in evaluation for purposes of financial or vocational benefits available for the mentally ill in India. Similarly the evaluation of the family and social milieu by the social worker is crucial to the community care of the mentally ill person. Table 8 on pages 61 and 62 shows that even the most basic of these tests is available in less than 2/3rd of the Government hospitals.

The availability of medical and psychosocial treatments in these hospitals also varies depending upon their development. Drug therapy is available in all the hospitals but in the crowded and understaffed hospitals, patients do not get the optimum supervised dosages. Modified electroconvulsive therapy (ECT) which is a crucial treatment in the management of acutely ill patients is available in only half the hospitals. As a result of these lacunae, control of violent behavior is achieved by using a combination of drug therapy, seclusion and physical restraint in 27(73%) hospitals. Psychosocial therapies are important adjuncts to the medical therapy for better recovery. The use of these therapies is scientifically proven to increase the efficacy of psychiatric treatment by about 30% compared to drugs alone. Rehabilitation of the patient and working with the family is crucial in community care and secondary and tertiary prevention. These techniques improve the patient's disability, reduce the family's burden and remove the stigma of the illness. The finding that these therapies are available in only about 2/3rd of our hospitals may explain the fact of longer duration of hospital stay, chronicity and rejection by the family members in places bereft of these facilities.

The charges for these medical and psychosocial investigations are based on the



hospital policy i.e. from totally free to charges on a slab system according to the patient's income.

A comparison of investigations and treatments available in the inpatient and outpatient services is provided in Tables 8 and 9 under Outpatient Services.

## **Rights of Patients**

The deficiencies in the areas described so far are enough indicators that the rights of the mentally ill are grossly violated in mental hospitals. Specific responses in some of the other areas relating to Rights were sought directly from the hospitals during the questionnaire survey. When asked whether the explanation of nature of illness, treatment and prognosis were provided, the respondents mentioned that such information was provided to all families in 24(65%) and to a few families in 11(30%) hospitals according to the respondents. How much relatives are told about the illness can only be determined by a separate study. Relatives and clients (when they are well) have a right to this information. This information is also important for compliance with treatment, normalizing expectations about the patient, and coping with problems. Family members were generally dissatisfied with the information they were given in most of the psychiatric hospitals in India.

Family members are allowed to visit patients in 25 hospitals (68%) and encouraged to take patients for an outing or for recreation in 30(81%). There should not be any restriction on visits by the family in the closed wards. Visiting hours should be prominently displayed, as family members are often turned away by ward attendants. In fact such interaction will help in keeping patients in touch with reality and facilitate their return to society. The relatives will also be aware of the improvement of the patient and can meet the staff for education about illness and management at home. It is better to insist that relatives visit the patient and the staff as frequently as possible so that they do not forget the patient and abandon them. The Mental Health Act, in Chapter VIII, Section 81 (3) says that letters and communication should not be intercepted, detained or destroyed. Most patients (in 36 hospitals), (97%) were allowed to write letters to their homes but only from 2 to 30% of patients made use of this facility. Patients are possibly not actively encouraged or helped to write these letters.

Only 28 hospitals (76%) allowed patients to talk to recognized /authorized social agency personnel. There was some liaison with outside lay volunteer agencies (like NSS, other agencies) only in 16(43%) hospitals. Liaison with NGOs' and volunteers helps in the rehabilitation process and also helps in changing public attitudes and stigma.

When asked whether staff were aware of the rights of the mentally ill, 15 respondents (41%) said all were aware, 16(43%) said few were aware and the others were not certain. In 28 hospitals (75%) it was reported that the staff were sensitized



about rights of the mentally ill but the visits revealed that most staff members were neither aware nor sensitized about rights. Sensitization of professionals and other staff should include facets like the right to treatment with respect and dignity, right against exploitation and abuse and right to proper treatment and family life.

## **Casualty and Emergency Services**

Emergency services are used by relatives when they have to seek treatment for patients who have an acute onset of illness or for excitement and violence during an exacerbation of illness. These services are present only in 22 (59.5%) of the hospitals visited. Where present, these services are generally easily accessible to the public. On an average about 25 patients are seen per day in 16 of these hospitals for which data was available. The type of illnesses seen are acute psychoses, schizophrenia, acute exacerbation of psychiatric disorders, and alcohol and drug withdrawal states. Most of these patients are admitted to the wards or treated on an outpatient basis. A few are referred to a magistrate for an admission order. Cases requiring admission are admitted promptly in 90% of the cases seen. Short stay wards in the casualty for brief hospitalization and treatment are present only in 12 (32.4%) of the hospitals and averaged 17 beds when present. Ambulance facility is available in 22 (59.5%) of the hospitals, but the team's visits showed that they were not easily available when a need arose. Routine bedside investigations are available in only about 10 hospitals though basic medicines are stocked in 24 (65%) hospitals. The conditions in the emergency services are inadequate as facilities like telephone services (48%), staff on duty (48%), and equipment (54%) are grossly inadequate. Only 32% of the hospital authorities felt there were adequate facilities in the casualty. An accessible casualty with a duty doctor available around the clock is required in all the psychiatric hospitals. These services are needed to instill confidence in the consumers that they can easily approach the hospital in times of a crisis as is seen with other medical emergencies in a general hospital.

## **Outpatient Services**

Out patient services are present in 36 (97.3%) of the hospitals visited and are conducted on a daily basis. These services are from 3-5 hours/day in 17 hospitals (47%) while it was for more than 6 hours/day in 19 hospitals (53%). On an average about 100 cases are seen per day in these hospitals (Range from 3-400 patients). Fourteen of these hospitals had 100-400 patients attending per day. Of these patients attending the outpatient, a mean of 7 patients were brought as emergency cases (Range 1-30), some of them chained or roped as a means of physical restraint by the family members.

Separate case files are present for each patient in 33 (89%) hospitals. Seventy percent of hospitals have staff ranging from 1-5 persons in the medical records department. However, in some hospitals, either there are no separate staff (e.g. IOP,



Goa) or the post is lying vacant causing great inconvenience (e.g. IMH Chennai). Case files are usually accessible only to the treating team and confidentiality is assured in most hospitals (92%).

Most of the outpatient departments have facilities like interview rooms (86%), waiting halls (89%), seating arrangements (84%), and free drugs (82%). In 14 hospitals (38%), the authorities rated their own services as adequate. Nineteen (51%) felt they were inadequate and 4 (11%) did not respond. This reflects the dissatisfaction of the hospital authorities with their services. The reasons cited for this deficiency include a lack of personnel, monetary resources or allocated space. Most of the authorities opined that good outpatient services were needed to impart adequate care, ensure good follow up and treatment compliance and reduce the number of hospital admissions.

While investigation and treatment facilities are in general inadequate in most hospitals, the facilities offered for outpatients in these areas are even more meagre. The range and relevance of these facilities has already been emphasized earlier. The following tables compare the investigation and treatment facilities in inpatient and outpatient settings across the 37 hospitals.

**Table 8. Comparison of Investigation facilities in Inpatient and Outpatient Settings.**

Medical Investigations	Inpatient (N)	Outpatient (N)
Routine Blood and Urine	29	21
Spl. Blood / CSF	11	7
Blood Sugar	21	13
VDRL	15	9
Lithium Estimation	14	11
X-rays	17	13
EEG	14	11
HIV screen	14	11
Hepatitis B screen	6	4
IQ/Cognitive functions	20	18
Personality Assessment	21	18
Diagnostic Tests	20	17
Home visits	12	9
Collateral Contacts	14	9



**Table 9: Treatments available in the Inpatient and Outpatient Settings**

<b>Medical Treatment (4Missing)</b>	<b>Inpatient</b>		<b>Outpatient</b>	
	<b>n</b>	<b>(%)</b>	<b>n</b>	<b>%</b>
Drug therapy	33	100	33	100
Direct ECT	33	100	33	100
Modified ECT	15	50	14	47
<b>Psychosocial Treatment</b>				
Psychotherapy/Counseling	29	85	28	85
Behavior Therapy	18	56	17	57
Psychoeducation	24	73	22	69
Rehabilitation	20	61	12	39

### **Human Rights Issues beyond Inpatient Care**

While patient rights have earlier been discussed in the inpatient context, it must be emphasized that they also apply equally to the outpatient and emergency treatment facilities. Mandatory outpatient and casualty services, an informed choice of residential or out-patient services to the consumers and their families, reduced waiting time, adequate waiting area, toilet facilities, courteous attention, mental health education, adequate investigation and treatment facilities in the out-patient and casualty are some of the relevant areas meriting attention. Periodic review and feedback from patients regarding the services would be useful to ensure ongoing monitoring of these facilities.

### **Conclusions**

In this chapter the findings relating to the psychiatric services in the governmental hospitals and some of the necessary changes are described and discussed. In summary, though the Mental Health Act, 1987 is 'fully implemented' only in 50% of hospitals, the process of admission and discharge has become easier and voluntary admissions are more. This has reduced the long stay patient population. There are many deficiencies in all aspects of inpatient care, which is woefully inadequate in a third of the hospitals in terms of inappropriate treatment, poorly maintained and unhygienic facilities, inadequate staffing and gross neglect of rights of persons. Though outpatient services are present in most hospitals the treatment is not comprehensive in terms of psychosocial inputs. Emergency facilities are rarely provided.



Relevant investigation facilities and comprehensive medical and psychosocial treatments are almost non-existent in over 1/3rd of our hospitals. Thus, as expected, the effect of inadequate finances and staffing, dilapidated infrastructure, poor attitude and morale of the staff and apathy of the governments adversely affects the hapless consumers, the mentally ill persons, who are unable to complain or demand their rights or expect a better quality of services they deserve.

## **STAFF PATTERN**

### **Introduction**

Any hospital relies on its staff to deliver services. Quality of care in the delivery of mental health services is directly dependent on the adequacy of trained personnel. An assessment of staff issues formed an important part of the project.

### **Adequacy**

Most of the Medical Superintendents (n= 30, 81%) reported that the staff position in their hospitals was inadequate. However, majority (n= 26, 70.3%) reported that the existing staff were adequately trained. Information regarding the various categories of staff, the number of existing posts, vacancies and reasons for the same were obtained during the survey. In the following section issues related to the staff will be discussed in detail. Table 10 and Figure 9 depict the mean of existing staff positions and numbers occupied and vacant.

### **Psychiatrists**

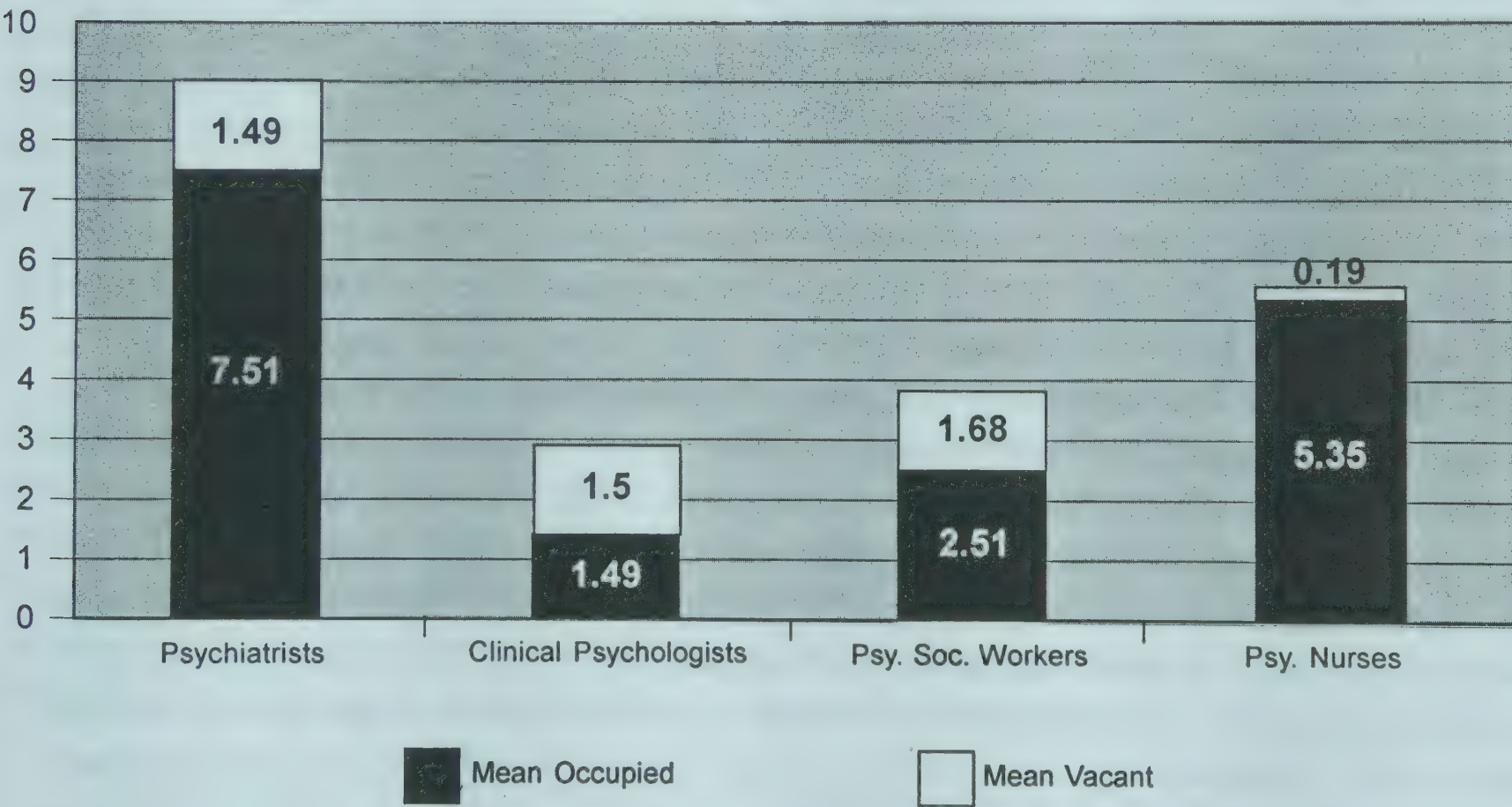
The services of a psychiatrist are available in all but 2 of the government mental hospitals. While 16% (n= 6) had only one psychiatrist, an additional 25% had 2 to 3 posts. For the purpose of this section the total number of psychiatrists reflects the sum total of professionally qualified staff both at the faculty and residents level. NIMHANS, Bangalore and CIP Ranchi are placed at the upper end with about 50 posts each, while Yeravada hospital at Pune and IHBAS at Delhi follow with 16 and 15 posts respectively. In violation of the provisions of the Mental Health Act 1987, the hospitals at Gwalior and Jamnagar did not have any psychiatrist at the time of the survey. The average number of psychiatrists per hospital is indicated in Table 10. However, this is not an accurate representation as there is a wide disparity amongst hospitals. In fact, if one excludes 4 hospitals at the higher end, namely, NIMHANS, IHBAS, CIP and IMH, Chennai the average drops to about 4 which is closer to the actual situation.



Table 10. Mental health professionals across hospitals

Mental Health Professionals	Total				Occupied		Vacant	
	Min.	Max.	Mean	SD	Mean	SD	Mean	SD
Psychiatrists	1	50	9.00	11.85	7.51	11.52	1.49	2.05
Clinical Psychologists	0	28	3.00	4.96	1.49	3.81	1.50	2.23
Psychiatric Social Workers	0	26	3.81	5.60	2.51	5.04	1.30	2.15
Psychiatric Nurse	0	52	5.54	11.77	5.35	11.77	0.19	0.57

Figure 9. Mean positions occupied and vacant for mental health professionals



One must however, evaluate the number of posts in relation to the bed strength of the hospitals. The psychiatrist-patient ratio recommended at the recently conducted Workshop for Medical Superintendents on Minimum Standards of Care is 1:10. While NIMHANS and CIP, Ranchi, are closer to an ideal ratio of 1:10, three hospitals namely IHBAS, New Delhi, Mental Hospital, Kohima and The Mental Health Institute at Cuttack meet the minimum standard. The majority of the hospitals fall short of the minimum and have ratios as skewed as 1:150 or even 1:200. This certainly raises the question as to whether patients in these hospitals are even receiving the basic minimum psychiatric care.



Of greater concern is the fact that many existing posts are lying vacant. At Gwalior all the 5 posts of psychiatrists are not filled. Issues of working hours, designation and pay scales are commonly cited reasons for the vacancies. In many places the general freeze on recruitment (e.g. Andhra Pradesh, Tamil Nadu etc.) has adversely affected the functioning of the hospitals. However, hospitals such as IHBAS and CIP despite being upgraded to function as training centers are plagued by similar problems with almost 50% of the posts being vacant. This suggests that service conditions and work environment are equally important.

## **Clinical Psychologists**

In almost one-fifth of the hospitals ( $n=8$ , 21.6%) there are no posts of clinical psychologists. More than 50% of the hospitals have 1 to 2 posts. However, posts are vacant in almost half of these hospitals. This is reflected in Table 10 where the mean number of posts is about 3 with approximately half of these being vacant. However, if one deletes the 4 large teaching and research centers mentioned earlier, the average number of posts drops to 2 with one being vacant. This results in 18 hospitals having no clinical psychologist and another ten having one. The minimum ratio recommended is 1:25 patients and the majority of the hospitals fall short of this standard. Disparity between the designation and requisite qualifications and the total emoluments not being commensurate with the former are cited as the main reasons for the large number of vacancies. It is imperative that there is uniformity in the designation and pay scale across the various hospitals. The post of clinical psychologist should be that of a Class I officers with the minimum qualification being an M.Phil degree or a minimum of 2 years of supervised clinical experience from a recognized program after the completion of Masters in Psychology. The scale of pay should be comparable to that of a lecturer in a university. However, wherever teaching is involved the minimum qualification can be that of M.Phil with Ph.D. in Clinical Psychology, with the designation of Assistant Professor. Promotional avenues must be provided. In the event of the non-availability of an adequately trained person the post may be downgraded to that of a psychologist and the person can be deputed for professional training at the earliest. However, while more attractive pay packages commensurate with qualifications are needed they alone may not suffice. This is borne out by the fact that a large number of vacancies continue in hospitals which have been upgraded as teaching and research institutes such as IHBAS, New Delhi, CIP, Ranchi or IMH, Chennai.

In addition, there has to be a change in the way these hospitals function and an attitudinal change on the part of the Medical Superintendent and the rest of the medical team. Many of the clinical psychologists in service are dissatisfied with the working conditions. This is mainly due to the fact that they felt they are underutilized. While their role as psychodiagnosticians is recognized and accepted, their contribution in terms of psychosocial interventions are not. In many places this has resulted in a



rapid turnover, with newly trained staff joining, but leaving the service, because of a lack of recognition of their role and poor job satisfaction.

## **Psychiatric Social Workers**

In eleven (29.7%) hospitals there is no post of a psychiatric social worker and 9 hospitals (24.3%) have one post each. The mean number of posts of psychiatric social workers is about 4 (drops to 3 when the 4 hospitals are excluded) with about one-third of these posts being vacant. In quite a few hospitals, the post is designated as that of a 'social worker' with a master's level qualification. Despite, many years of service they have not been considered for any special training or upgrading of skills. In other hospitals, it is a case of under-utilization of professional skills. There were complaints that instead of being recognized as mental health professionals their services were used like that of clerical staff or limited to history taking and keeping records pertaining to patients with legal problems.

A good example of the role that psychiatric social workers have played in reducing the long stay of patients and successfully discharging and or rehabilitating patients 'dumped' in the hospital has been at NIMHANS, Bangalore. It is, therefore, important to ensure that posts of psychiatric social workers are created in keeping with the recommended ratio of 1:25 and that their services are utilized appropriately.

## **Medical Officers**

Most of the mental hospitals had an adequate number of medical officers (MOs). While the average was 7 (Table 11), Yeravada, Pune, NIMHANS, Bangalore, IHBAS, New Delhi, IMH, Chennai, and hospitals at Gwalior, Kozhikode and Tezpur had a relatively large number of medical officers being almost 2 to 3 times the average. It was found that only at NIMHANS was their role clearly delineated and limited to screening of new cases at the time of registration. In most other centers, they function in an ancillary role to the Medical Superintendent who is the only psychiatrist.

The MOs play a crucial role in monitoring the physical health of the patients. In majority of the hospitals it was found that the routine medical care was grossly adequate. In some, hospitals such as in Baroda the MOs are particularly motivated and responsible and have evolved a good monitoring system whereby review charts are maintained to ensure that each patient undergoes a routine physical examination twice a month. In some hospitals the MOs, who have undergone short-term training in psychiatry, are subsequently transferred and are unable to effectively utilize this training. In Ahmedabad a medical officer underwent a one-month training at the Department of Psychiatric and Neurological Rehabilitation at NIMHANS and was able to significantly improve the occupational therapy services on his return.



However, the majority do not have any special training in the care of the mentally ill. As a result, they are usually in charge of monitoring the treatment prescribed by the psychiatrist. Many of the MOs have specializations in other fields such as pediatrics, obstetrics and gynecology etc. This often results in their feeling frustrated in terms of not having work satisfaction and feeling that the State Governments were not adequately utilizing their services.

## **Psychiatric Nurses**

The mean number of psychiatric nurses as seen in Table 10 is about 5 with almost all these posts being occupied. Again, however, when one excludes the larger institutions, this average shows a drop to about 3. The recommended ratio of nurses to patients is 1:3 for a teaching hospital and 1:5 for a non-teaching hospital. Barring a few institutions, these ratios are a far cry from the ground reality. The survey revealed that 19 hospitals (51%) did not have a post of a psychiatric trained nurse. Ideally speaking, all nurses in a psychiatric facility should have undergone training in psychiatric nursing. Hospitals, which have at least one such nurse, are qualitatively superior in terms of in-patient care when compared to other hospitals, which have none. Some states such as Maharashtra had deputed one or two nurses from each of their hospitals to NIMHANS for the diploma course in psychiatric nursing. This has resulted in a significant improvement in the quality of care.

## **Nurses**

One would imagine that there could be no hospital without nurses. The survey revealed that 4 (10.8%) mental hospitals are actually functioning without the services of any nursing personnel. These are the Hospitals in Bareilly, Varanasi, Agra and Kohima. How such an anomaly has continued without any corrective action on the part of the administrators is a question of concern! Such hospitals function more like prisons providing custodial care rather than therapeutic services, and are in violation of the patient's basic right to proper treatment. Most of the other hospitals had an adequate

Number of general nurses, with the average being 43 with more than two-thirds of these posts being occupied.

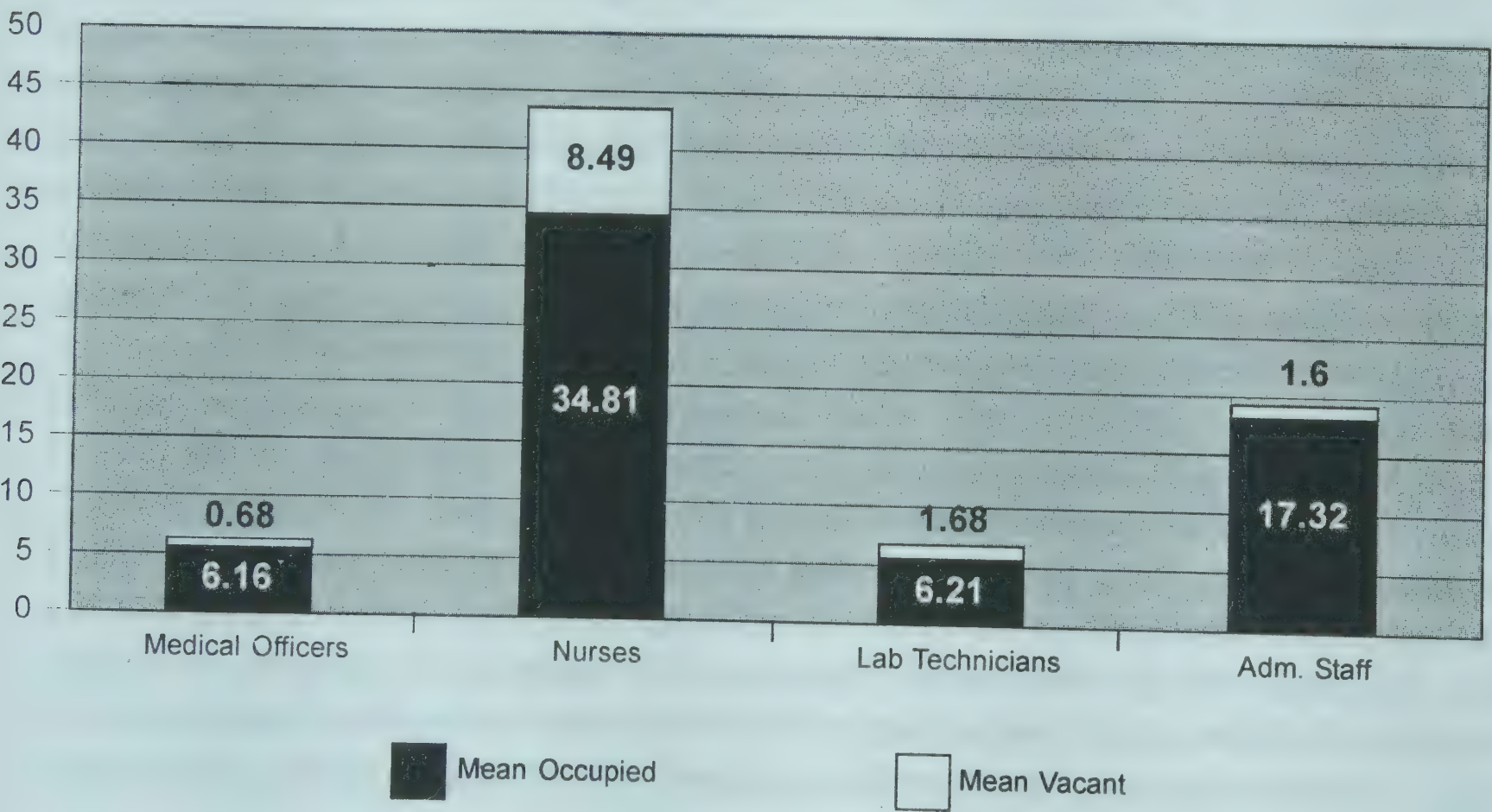
Table 11 and Figure 10 show the mean total of other categories of staff across mental hospitals and the number occupied and vacant



Table 11. Other Categories of Staff

Other staff	Total				Occupied		Vacant	
	Min.	Max.	Mean	SD	Mean	SD	Mean	SD
Medical Officers	.1	28	6.84	6.93	6.16	6.09	0.68	1.56
Nurses	0	174	43.30	40.73	34.81	27.85	1.49	19.10
Lab. Technicians	1	109	7.89	18.53	6.21	17.86	1.68	4.97
Administrative	0	180	18.92	31.50	17.32	30.67	1.60	3.15
Group D	1	909	151.00	183.16	130.30	156.83	20.70	33.57

Figure 10. Mean positions occupied and vacant for other staff



Administrative Staff

In majority of the hospitals the number of administrative staff is adequate with hardly any vacancies. However, in most of the hospitals the office infrastructure is



very basic and even primitive. Offices need to have at least one computer and the skills of the staff can be upgraded where necessary. One common concern expressed in most of the hospitals was the need for a separate medical record section. Currently, in many centers, the services of a clerical staff are being used for this purpose. Maintaining a good medical record section is an integral and important function of the hospital. Records should be preserved in good condition and confidentiality should be kept. Apart from this the data generated will help in organizing the existing services more efficiently as well as help in planning for expansion of the services. Trained personnel under a Medical Records Officer are therefore warranted.

### **Laboratory Technicians**

Most of the hospitals do not have specialized laboratory facilities. However, majority (n= 30, 80%) have basic laboratory facilities with the necessary staff. In addition, other technical staff have also been included here such as EEG technician, pharmacist, dietician etc. Overall, the staff position here is commensurate with the services that are available.

### **Attenders, Peons and Other Group D Staff**

Majority of the hospitals have a large number of group D staff. This is reflected in the average number of posts being 151 and includes other staff involved in the kitchen, garden and cleaning. Most of these positions were created at a time when the hospitals provided only custodial care. Designations such as 'Warder' and 'Overseer', which are still prevalent, are reminiscent of the prison. A large majority of workers at this level are illiterate and believe that their job is to keep the patients 'quiet'. Many of the infringement of patient's rights take place during the evening and nights in these hospitals when the warders are 'in charge' and only one nurse or duty doctor is available on call. Many instances of excited or aggressive patients being beaten up and locked in a cell were reported during the visits by the project team. In some cases the possibility of sexual abuse is suspected. For e.g. In Amritsar, female attendants have been suspended for negligence of duty because a female patient delivered a baby in the ward without any of the staff even realizing that she was pregnant. In the Institute of Psychiatry, Calcutta all the patients have been discharged, following the suspension of all 14 attenders on account of negligence of duty. In other hospitals, they have been accused of corrupt practices such as taking money from family members and promising admission.

The group D staff voiced several difficulties and concerns. They complained of the difficult working conditions. Many felt that they are the ones with maximum contact with the patients. Often at risk to their own lives, an excited or violent patient has to be held down by them so that the patient can be sedated. They do not receive adequate support from the medical staff who finishes duty by 2 pm in the afternoon. The onus of responsibility is on them to manage the patients till the next



morning. Conditions such as overcrowding and long hours between meals make patients more irritable. They are unjustly blamed when patients become violent and start fighting amongst themselves and sustain injury. The cleaning staff has an even more difficult time. In the hospitals at Indore, Ahmedabad, Amritsar etc for e.g., there are no toilet facilities for the male patients and the sweepers have to clean open drains with fecal matter.

On the other side of the coin, the administrative staff reports mainly disciplinary problems. In large hospitals such as Thane and Yeravada, the group D staff often have more than one union and at times may be in conflict with one another. It is usual practice to have the entire group D staff under the direct supervision of the nursing matron. However, in hospitals, which have the post of the overseer, the male attenders come under their charge and not that of the matron. This causes difficulties for the nursing staff in carrying out routine functions, especially if the overseers are not cooperative. Medical superintendents report that the mental hospital is treated like rehabilitation or punishment center and staff with disciplinary problems from other departments are transferred to the mental hospitals.

Some hospitals have already started downsizing the number of staff in this category by not filling posts that falls vacant on retirement. In others, where there is a shortage of staff and a need to fill existing vacancies, the state government may be having a general freeze on recruitment. Although they are not responsible for the non-recruitment, in a few hospitals the superintendents are being targeted by the staff unions for unfair practice. IHBAS, New Delhi managed to reduce the number of staff in this category by reallocating them to other state departments.

A progressive step has been the privatization of services such as security, cleaning and garden maintenance in many hospitals (For e.g. NIMHANS, Bangalore, IHBAS, New Delhi, RINPAS, Ranchi etc). This seems to be a viable and better alternative, provided that there is an adequate system of monitoring the quality of these services.

A system of incentives needs to be worked out for motivated and committed staff. For e.g. in the hospitals in Ratnagiri and Ahmedabad, attenders with some talent and sensitivity have been identified and are involved in the recreational activities of the patients. They need to be rewarded by either upgrading their scale to that of instructor or giving them additional increments.

Recruitment rules need to be changed for this cadre. A minimum educational level of 10<sup>th</sup> standard can be introduced so that following their selection they can be trained to handle psychiatrically ill persons. They can be designated as nursing aides and be under the direct supervision of the nursing staff. The proportion of female to male aides has to be kept in keeping with the gender distribution of the patients.



## Visiting Consultants

Majority of the hospitals does not have any visiting consultants. Patients are sent to the local general hospital in case of any emergency or medical/surgical problems. Although these consultations are infrequent, difficulties in terms of transporting the patient (lack of ambulance) and, in the event of admission, attender to care for the patient are cited. Most of the superintendents felt that a panel of specialists designated for the mental hospital would be a better alternative. Such consultations could then be arranged in the hospital itself and only those requiring more specialized care or admission need be sent to the general hospital. Such an arrangement is available in some hospitals such as NIMHANS, Bangalore.

In most hospitals the services of an anesthetist is necessary in view of the fact that it is ethical practice to administer modified ECTs (electroconvulsive therapy) unless otherwise contraindicated. A full time post of an anesthetist in a mental hospital setting may not be warranted, but a regular attachment is desirable. In many hospitals, ECT's are not being given because of the non-availability of an anesthetist or the patients have to be sent to the local general hospital for the same. In other instances, the ECT's are given in an adhoc manner subject to the availability of the services. Since appropriate scheduling of ECT's is important, this needs greater attention. Other services that should be available on a routine basis are that of a physician, dentist, neurologist and gynecologist. This is particularly important as most of the hospitals have a large number of elderly patients who require greater medical attention. The large number of deaths in some of the hospitals is a cause for concern.

## Working Hours

The mean number of working hours for the medical staff is about 6 hours (the most common pattern being 8 am to 2 pm). The timing of the medical staff is not conducive to providing adequate care to the patients. Moreover, in actual practice the number of hours spent by the medical personnel may be less since they may be engaged in private practice. The time spent in the hospital is used for running the outpatient services, if any, and doing a routine round of the wards. Patients reported as requiring attention by the nurse on duty are seen individually. For the large part of the day and the night only the services of the duty doctor are available. In most places the justification given is that the medical superintendent and the resident medical officer usually stay in the premises of the hospital and are, therefore, available whenever necessary. However, when this is not the case as for e.g. in Jamnagar, attenders have had difficulty in controlling patients at night when they have attacked each other, sometimes leading to homicide.

For non-medical and other staff the working hours are approximately 8 hours



from 9 am to 5 PM. Nurses and attenders work on shift basis. In many places because of shortage of staff and inadequate leave reserve staff, nurses and ward attenders have to work much longer hours and cannot avail the leave due to them.

## **Service Conditions**

Majority of the hospitals (n= 27, 73%) reported that overall service conditions were satisfactory. At the same time the level of burnout reported has been fairly high. Burnout is a well-accepted condition of emotional exhaustion and reduced personal accomplishment reported in people in the caregiving professions. While about half the hospitals (n= 21, 57%) did not provide information on actual percentage of staff burnout, they have cited several reasons for the same. NIMHANS, Bangalore and IHBAS, New Delhi reported no staff burnout, citing “highly motivated staff” as the reason. However, this may not be applicable to all levels and categories of staff. At the other extreme, the hospital in Trichur reported a staff burnout of 95%. Burnout is high and uniformly present at the lower cadres across all the hospitals and greater attention has to be paid to this neglected area.

Some of the reasons given in response to the survey were that of having to work with large numbers of chronic patients, inadequate recognition of good work, lack of incentives and promotions especially for committed staff, and absence of opportunities for attending workshops and training.

Remedial measures need to be instituted for different categories of staff. Better pay packages, risk allowance, health insurance and housing in terms of staff quarters should be provided for all. Better working conditions and facilities such as staff rooms, toilets, changing rooms for nurses and attenders, drinking water etc are also necessary. Committed and motivated staff should be deputed for in-service training to upgrade their skills and be given additional increments. There should also be promotional avenues. Professional staff should attend at least one workshop or conference a year so as to be in touch with the newer developments in the field. Library facilities should be improved and wherever possible some provision for conducting research provided.

## **Administrative Setup**

The medical superintendent should be a psychiatrist and the overall in-charge of the hospital. This is necessary to ensure the smooth running of the hospital. For e.g. in West Bengal, all admissions to the mental hospitals have to be ratified by the Health Secretariat. This is not only against standard hospital practice, but lends scope for corrupt practices and causes great inconvenience to the patient and his family.

In some hospitals (n=6), the superintendent is the sole psychiatrist with the



entire clinical and administrative responsibility. In order to provide quality care the superintendents need adequate staff, especially in terms of mental health professionals.

It was observed that wherever the medical superintendent has frequent formal and informal interactions with the staff the work atmosphere is much more positive. This is evident in hospitals such as in Ratnagiri and Tezpur where the staff are more cooperative and work as a team.

## SUGGESTIONS

- All the mental hospitals must immediately comply with the Mental Health Act 1987 and ensure that the medical superintendent is a psychiatrist.
- The beds should be divided into functional units of 25 each with one psychiatrist in charge.
- Appointment of clinical psychologists and psychiatric social workers to be done immediately. It is imperative that all existing posts be filled. New posts need to be created in hospitals, which do not have any of these staff. Pay scales must be fixed commensurate with qualification. Medical personnel need to be sensitized to the roles of other members of a multidisciplinary team.
- Where there is shortage of professional staff, till such a time as the vacancies are filled, part-time or visiting consultations can be provided.
- All posts of psychiatric nurses must be filled up immediately. Nurses in the general cadre can be deputed for training and be upgraded.
- Group D staff must be redesignated as nursing aides. Outdated posts such as that of 'water woman', 'durry woman' and 'engine driver' must be abolished and total number of posts must be reduced.
- Other supportive services such as cleaning, gardening and security can be privatized and given on annual contract to ensure that quality is maintained.
- All categories of staff should be sensitized and made aware of the rights of the mentally ill.
- Adequate recognition of good work in the form of increments or awards.
- Improvements in staff facilities such as staff room for all categories better toilet facilities and work environments.



- For professional and technical staff provision for attending at least one workshop/ seminar or conference per year. Computer and library facilities and budget allocation for research.

## CONCLUSION

Figure 9 clearly demonstrates that the composition of the mental health professional team is far from adequate. While the number of psychiatrists, clinical psychologists and psychiatric social workers should be about the same so that they can form a complete functional unit, the number of psychiatric nurses should be at least double. The roles of each of the mental health professionals are clearly defined and need to be recognized. This will result in greater accountability and improvement in overall delivery of mental health care. While a certain degree of overlap in roles is inevitable, it should not be seen as a threat. In conclusion, the success of mental health care depends largely on the efforts of an effective multi-disciplinary team.

## BUDGETARY ISSUES

### Introduction

The discussion so far has covered facilities, services and human resources. But lying behind all these are the financial resources to provide these services. Mental health services have generally received low priority, especially in terms of funding. In order to obtain a clear picture of the financial aspects of the psychiatric hospitals, all the hospitals were requested to provide total budget allocation over the years 1992- 1996, indicating plan and non plan break-up. For each year, they were also requested to indicate percentage of budget expenditure on staff, drugs, diet, furniture, linen, maintenance and any other special funds they had received. For convenience, comparisons across hospitals has been relative to bed strength (Figures 11, 12 & 13)

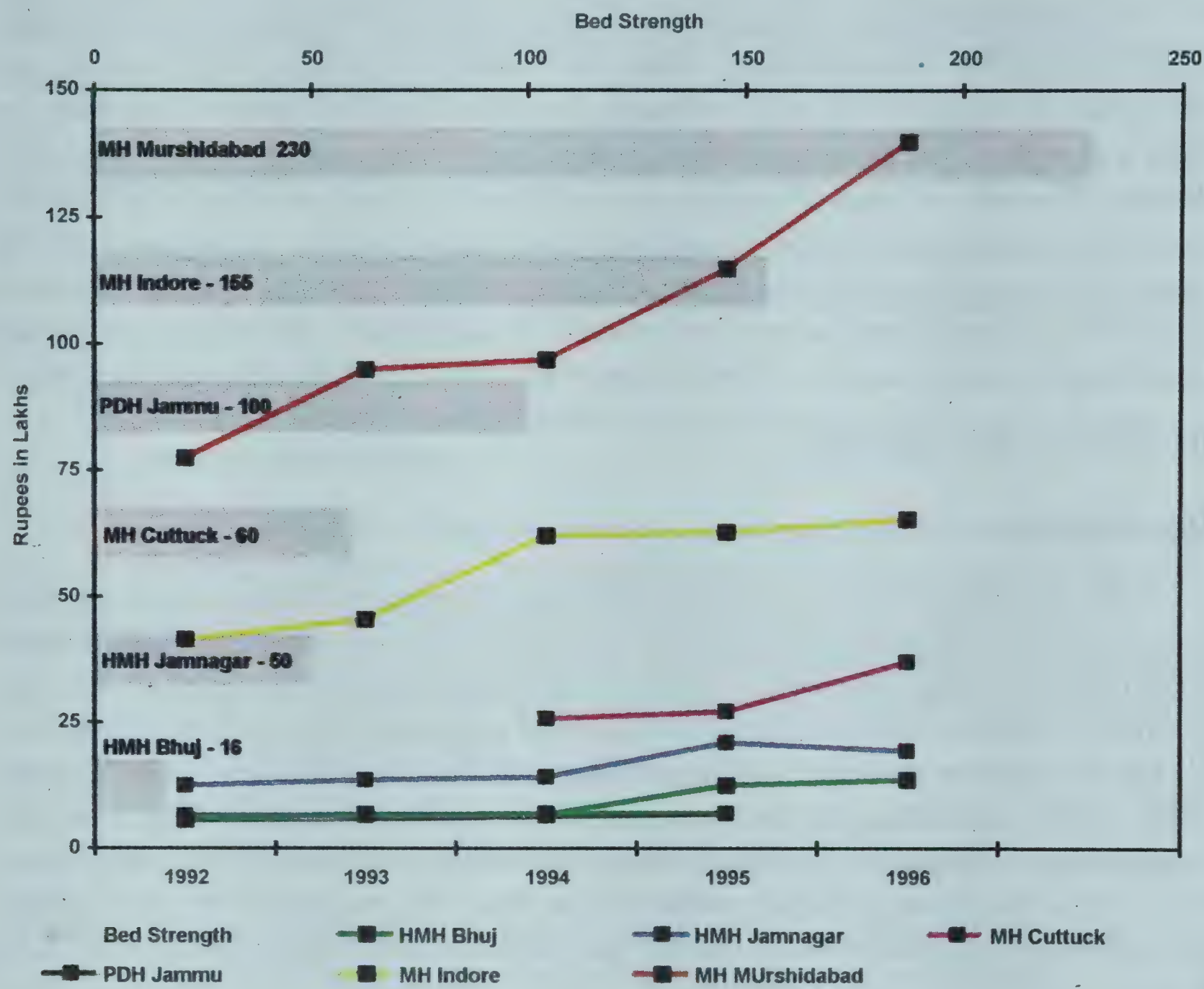
Six of the hospitals did not indicate either total budget or budget break-up across the years. Only fourteen (37.8 %) of the hospitals had a plan budget sanctioned during the five year period. Of the fourteen, three did not receive plan funds across all the five years. Plan budget is provided for developmental activities. It seems that in 23 (62.2%) of the hospitals, no developmental activity has been possible.

NIMHANS and IHBAS have been left out of the budget analysis. The former is a multidisciplinary institute with additional services in neurology, neurosurgery, paraclinical and basic science departments. The budget for the year 1996 was Rs 1270 lakhs (Non plan) and Rs 684 lakhs (Plan). Since the budget includes expenditure on all these facilities, it would not be appropriate to compare it with other psychiatric hospitals.



The IHBAS has had very large grants during the five years under consideration e.g. Rs 800 Lakhs under Non plan in 1996. Hence, its budget has also not been represented in the graph

Figure 11. Small Hospitals: Budget for 1992 to 1996

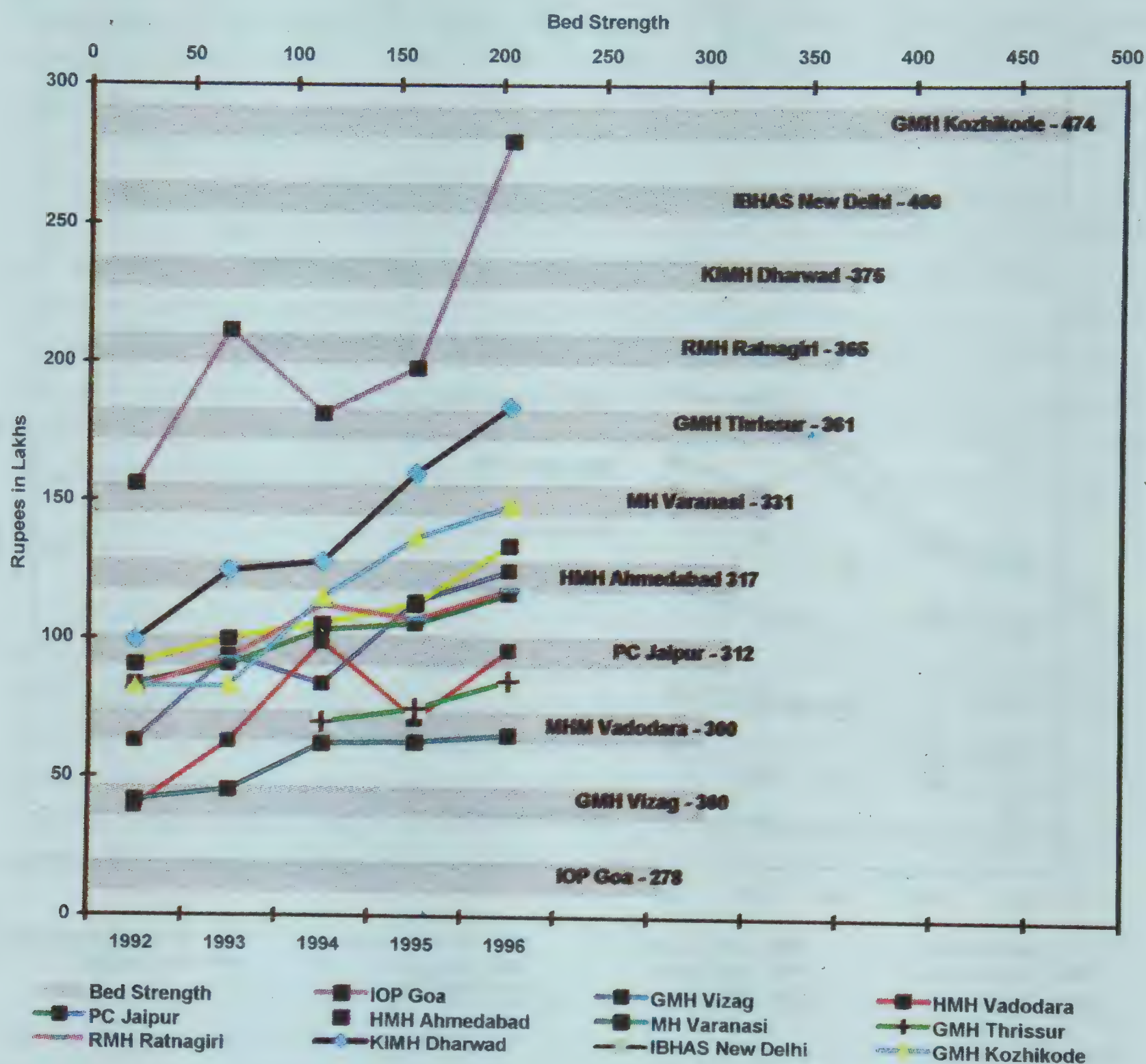


Figures not provided by MH Kohima (25), I of P Calcutta (36). IMH, Purulia, Calcutta (80). TMH Calcutta (180). GMA Gwalior (212)

The budget of the individual hospitals is indicated by the colored lines. The grey columns provide an idea about bed strength in each hospital. Thus the budget of HMH Bhuj with 16 beds (indicated by the green line) has almost trebled from 5.7 lakhs in 1992 to 13.7 lakhs in 1996. The budget of Murshidabad (230 beds)has doubled (top red line) from75 lakhs to 140 lakhs. On the other hand, the budgets of Indore and Jamnagar have increased about one and half times.



Figure 12. Medium Hospitals: Budget 1992 to 1996



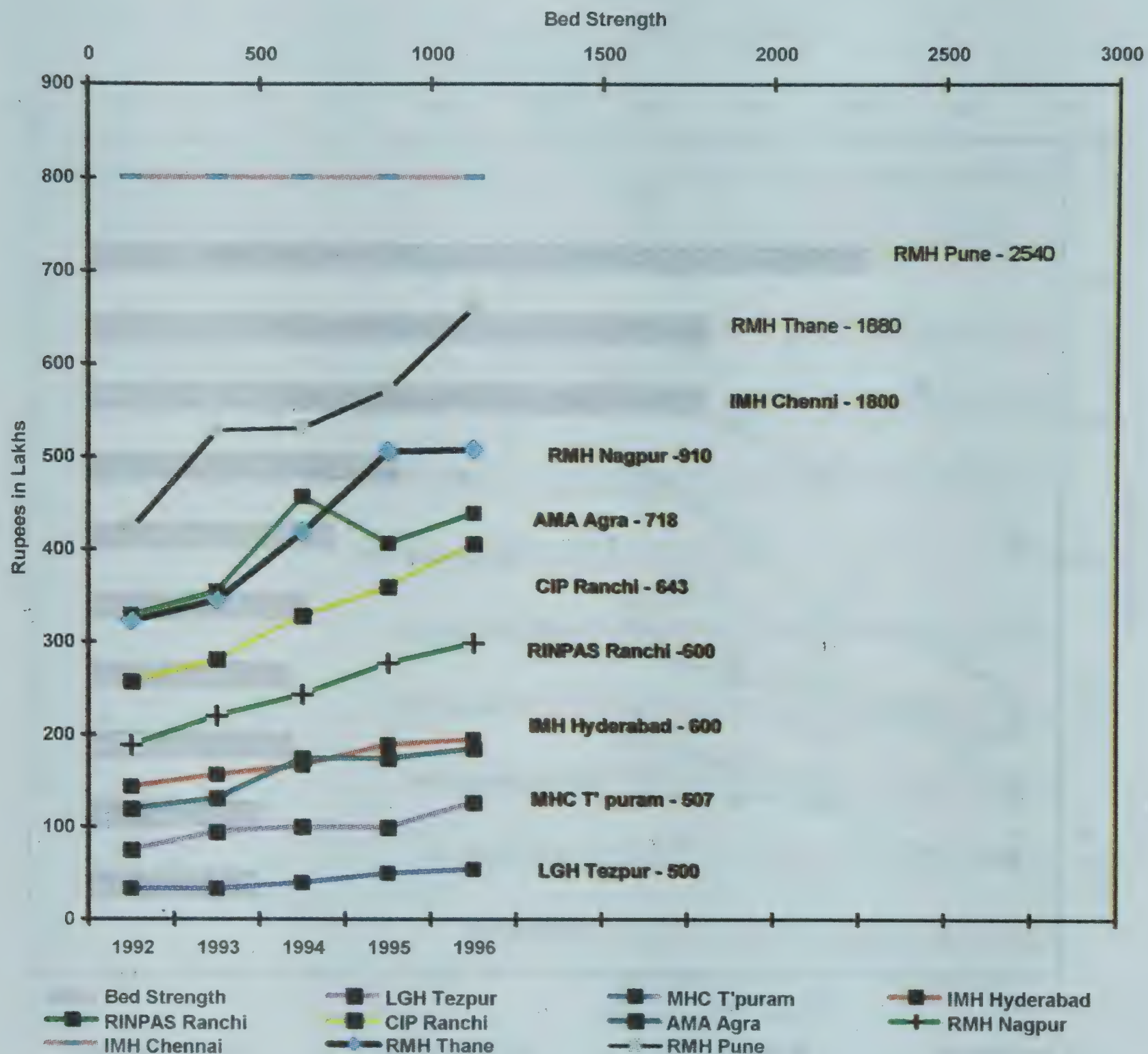
Figures not provided by CPH Calcutta (250), LPMH Calcutta (25), MH Barielly (300)

IBHAS New Delhi is an autonomous multi-disciplinary institute (Budget for '92 - 1087 lakhs, '93 - 700 lakhs, '93 - 800 lakhs)

Goa has had the maximum budget increase over the period, related to funds towards the new building. The budget at Dharwad has nearly doubled. Other budgets have increased one and a half times. MH Varanasi has had the least increase (41.6 to 65.4 lakhs)



Figure 13. Large Hospitals: Budget 1992 to 1996



Among large hospitals, the budgetary increases have been less pronounced. Increases are about one and half times in Pune and Thane. The budget increase for Hyderabad has been most meagre from 142.8 to 194.3 lakhs. The budget of Chennai has been static at 800 lakhs. Although it appears that budgets have significantly increased recently, they are still far from adequate and extremely variable and still inadequate, considering the inflation rate. While allotting budget to mental hospitals, inflation, revision of pay and DA of staff must be taken into consideration. Additionally increase in the hospital budget has not commensurately improved the quality of care. All the hospitals should have plan and non-plan budget. Additional funds should be provided for developmental activities.



## **BUDGETARY BREAKUP**

### **Staff**

The break-up of budget is also provided in the figures 14,15 and 16. Relative spending on staff budget in the year 1996 varied from 29% in Cuttack to 88% (in the hospital at Murshidabad). In medium size hospitals, budget expenditure on staff ranged from 53% at Dharwad to 80% at the Calcutta Pavlov Hospital. Large sized hospitals spent between 29% (IMH, Chennai) to 82% (CIP, Ranchi). The low figures in some of the places could reflect a large number of vacancies, as in IMH, Chennai. This highlights the lack of human resources. Staff need to be adequately paid and satisfied themselves if they have to provide quality care to their wards. However, the high percentage of funds spent on staff reduces the budget available for other patient care activities. A higher spending on staff certainly does not automatically translate into better service. This is best exemplified by the hospital at Murshidabad, which appears to spend the maximum on staff salaries but stands first in providing the worst services in the country.

### **Drugs**

Small hospitals spend between 1 to 6% on drugs, medium 3 to 14%, and large 1 to 6 %. Expenditure on drugs did not seem to be in proportion to bed strength. Some of the hospitals have the latest pharmacological drugs available to the patients while others are still administering sub therapeutic doses of chlorpromazine alone. Inadequate funds for drugs leads to a spiraling chain of events : improvement is delayed, patients stay longer, leading to chronicity and disability and finally greater expenditure on hospitalization.

### **Diet**

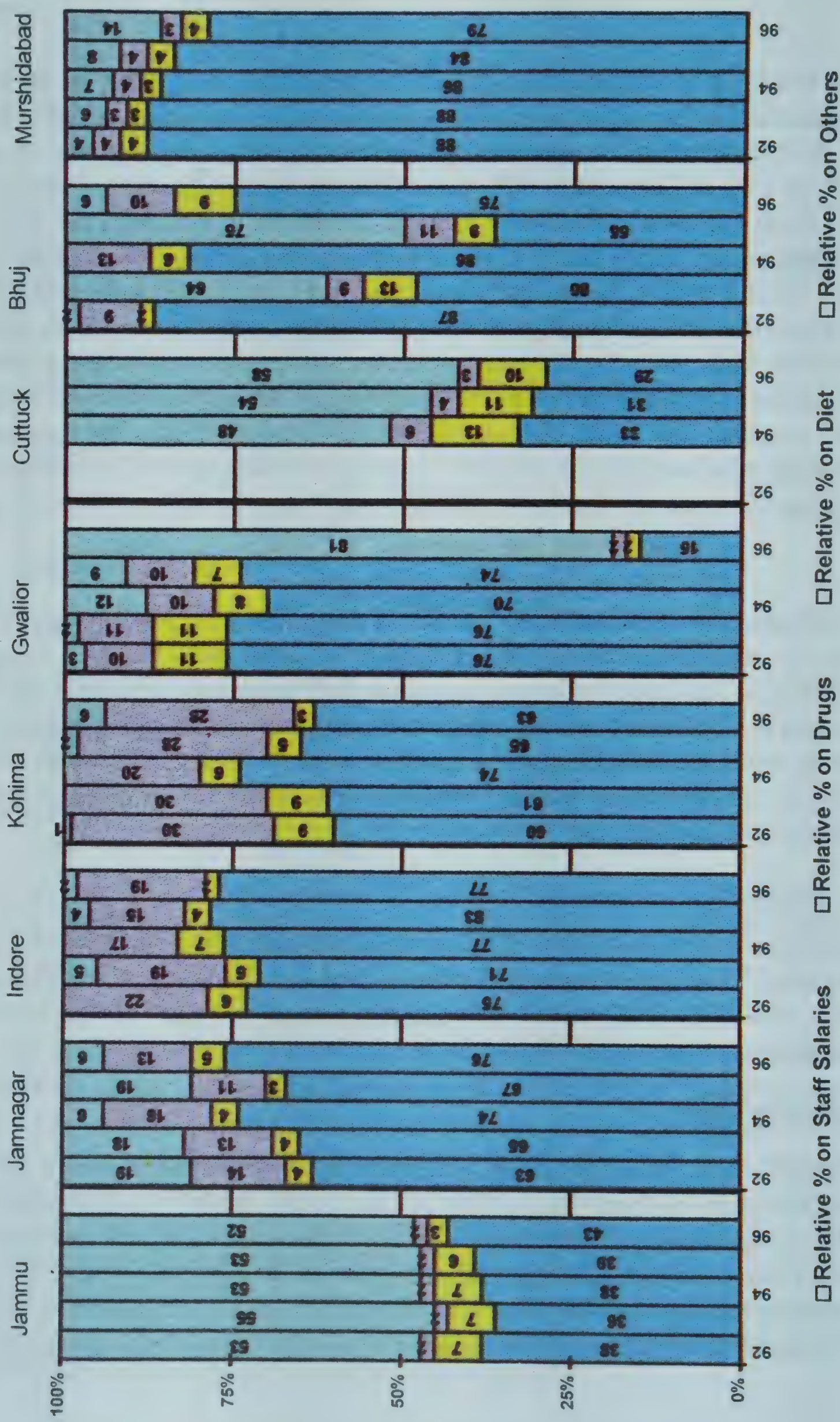
Individual cost of diet across different states has already been discussed. Small hospitals spend 2% (Gwalior) to 28% (Kohima ), medium 4% (Goa) to 27%(Thrissur), and large 10% (RINPAS) to 19% (Pune). It is best to calculate budget for food based on daily provision of 2500 calories per person per day.

### **Other expenditure**

Budget for linen is not provided in many of the hospitals, and where it is,, has been very low (varying from 0.01 to 3.6% in 19 hospitals. Budget for equipment has virtually been non-existent. Budget for furniture is also minimally provided in a few hospitals. There is no regular budget for maintenance in many hospitals (27, 73%). Where present it ranged from 0.01 to 7.1%. Linen is a basic requirement in all hospitals, In mental hospitals at least five sets of linen must be provided per patient.



Figure 14. Small Hospitals: Budget for 1992 to 1996





## Individual Costs of Maintaining a Patient

The individual cost of maintaining a patient in small, medium and large mental hospitals was calculated, based on the 1996 hospital budget details provided by each institution. This has been represented in Tables 12, 13 & 14 in 3 groups based on bed size.

**Table 12. Approximate cost of maintaining a patient in a Government psychiatric hospital (Small Mental Hospitals)**

Hospital	Bed Strength	Budget 1996 (in Lakhs)	Cost per year	Cost per day
HMH Bhuj	16	14	87,500	239.70
HMH Jamnagar	50	19	38,000	104.1
MH Cuttuck	60	37	61,666	168.9
PDH Jammu	100	7(1995)	7,000	19.2
MH Indore	155	65	41,936	114.9
MH Murshidabad	230	140	60,870	166.8
MH Kohima	25	NA		
IOP Calcutta	36	NA		
IMH Purulia	80	NA		
TMH Calcutta	180	NA		
GMA Gwalior	212	NA		



**Table 13. Approximate cost of maintaining a patient in a Government psychiatric hospital (Medium Mental Hospitals)**

Hospital	Bed Strength	Budget 1996 (in Lakhs)	Cost per year	Cost per day
CPH Calcutta	250	NA		
LPMH Calcutta	250	NA		
IOP Goa	278	280	1,00,719	275.90
MH Bareilly	300	NA		
GMH Vizag	300	125	41,667	114.20
HMH Vadodara	300	96	32,000	87.70
PC Jaipur	312	116	37,180	101.90
HMH Ahmedabad	317	134	42,271	115.80
MH Varanasi	331	65	19,637	53.80
GMH Thrissur	361	85	23,546	64.50
RMH Ratngiri	365	118	32,329	88.60
KIMH Dharwad	375	184	49,066	134.43
GMH Kozhikode	474	148	31,224	85.50

**Table 14. Approximate cost of maintaining a patient in a Government psychiatric hospital (Large Mental Hospitals)**

Hospital	Bed Strength	Budget 1996 (in Lakhs)	Cost per year	Cost per day
LGH Tezpur	500	127	25,400	69.60
MHC Thirvanthapuram	507	54	10,800	29.60
IMH Hyderabad	600	194	32,333	88.60
RINPAS Ranchi	600	439	73,167	201.00

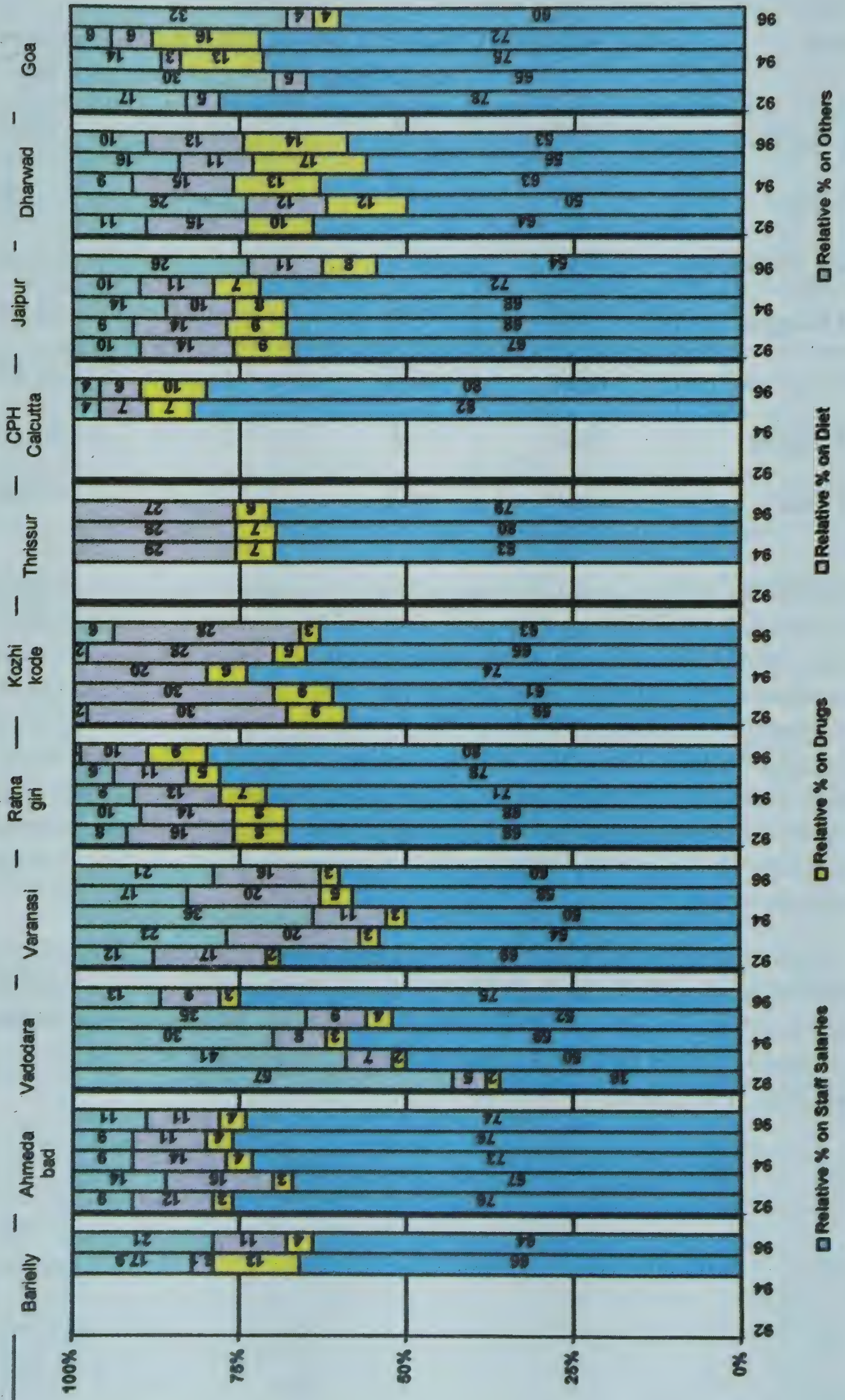


Hospital	Bed Strength	Budget 1996 (in Lakhs)	Cost per year	Cost per day
CIP Ranchi	643	406	63,142	173.00
AMA Agra	718	185	25,766	71.00
VGMH Amritsar	811	NA		
RMH Nagpur	910	299	32,857	90.00
IMH Chennai	1800	800	44,444	121.80
RMH Thane	1880	508	27,021	74.00
RNH Pune	2540	662	26,063	71.40

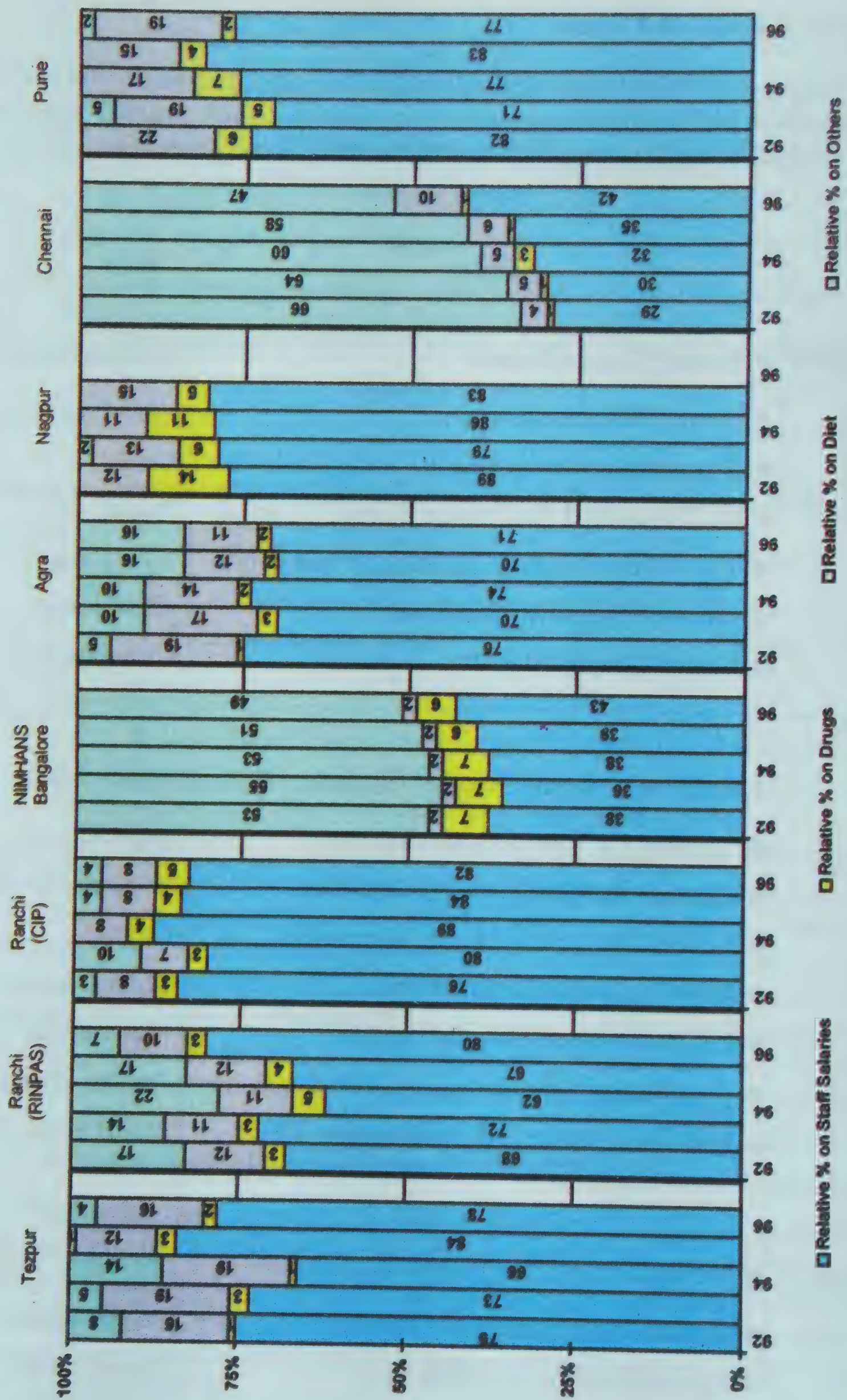
NIMHANS, IHBAS, and Goa were left out of the analysis of cost. Goa recently received funds for building new hospital. NIMHANS is not a mental hospital in a strict sense. IHBAS has recently received funding of several crores for developing it on the pattern of NIMHANS. The figures for MHC, Thiruvanthapuram (Rs 29.6/day), Varanasi (Rs 53.8/day), Thrissur (Rs 64.5/day), Tezpur (Rs 69.6/day), Agra and Pune (Rs 71/day), Thane (Rs 74/day), Ratnagiri (Rs 88.6/day), Kozhikode (Rs 85.5/day), Nagpur (Rs 90/day) are to say the least, shocking. The average amount being spent on maintaining a patient currently in an Indian psychiatric hospital is approximately Rs 106 per day (SD 51.9). This figure does not take into consideration outpatient costs.

The above disparities in the cost of maintaining patients across different hospitals must be corrected. As an immediate step, cost per patient per day should be increased to at least Rs 200/-. After ensuring the provision of adequate budget, monitoring to ensure proper distribution and utilization, to ensure that it finally reaches the consumer - the patient.











## Donations in Cash and Kind

Donations in cash are accepted in only 6 (16.2%) and donations in kind in 20 of the 37 hospitals(54.1%). Some hospitals which have received sizeable donations through cheques are unable to encash it because of the State Government policy.

## Grading

Rating	Hospital	State
<b>1</b> <b>Very poor</b>	<ul style="list-style-type: none"> <li>● Mental Hospital Indore</li> <li>● Mental Hospital Varanasi</li> <li>● Government Mental Health Center Kozhikode</li> <li>● Dr. Vidyasagar Government Hospital Amritsar</li> <li>● The Mental Hospital Calcutta and Mankundu</li> <li>● Mental Hospital Murshidabad</li> <li>● Mental Hospital Bareilly</li> </ul>	Madhya Pradesh Uttar Pradesh Kerala Punjab West Bengal West Bengal Uttar Pradesh
<b>2</b> <b>Poor</b>	<ul style="list-style-type: none"> <li>● Regional Mental Hospital Thane</li> <li>● Hospital for Mental Health Jamnagar</li> <li>● Hospital for Mental Health Vadodara</li> <li>● Hospital for Mental Health Ahmedabad</li> <li>● Regional Mental Hospital Pune</li> <li>● Regional Mental Hospital Nagpur</li> <li>● Government Mental Hospital Vishakapatnam</li> <li>● Institute of Mental Health Chennai</li> </ul>	Maharashtra Gujarat Gujarat Gujarat Maharashtra Maharashtra Andhra Pradesh Tamil Nadu
<b>3</b> <b>Average</b>	<ul style="list-style-type: none"> <li>● Institute of Mental Health Hyderabad</li> <li>● Regional Mental Hospital Ratnagiri</li> <li>● Agra Manasik Arogyashala Agra</li> </ul>	Andhra Pradesh Maharashtra Uttar Pradesh



	<ul style="list-style-type: none"> <li>● Gwalior Manasik Arogyashala Gwalior</li> <li>● Mental Health Center Thiruvanthapuram</li> <li>● Calcutta Pavlov Hospital Calcutta</li> <li>● Institute of Psychiatry Calcutta</li> <li>● Psychiatric Center Jaipur</li> <li>● Government Mental Hospital Thrissur</li> <li>● Karnataka Institute of Mental Health Dharwad</li> <li>● Lumbini Park Hospital Calcutta</li> </ul>	Madhya Pradesh Kerala West Bengal West Bengal Rajasthan Kerala Karnataka West Bengal
<b>4</b> <b>Good</b>	<ul style="list-style-type: none"> <li>● Psychiatric Disease Hospital Jammu</li> <li>● Institute of Behavior and Allied Sciences Delhi</li> <li>● Ranchi Institute of Psychiatry and Allied Sciences, Ranchi</li> <li>● Central Institute of Psychiatry Ranchi</li> <li>● L.G. B. Institute of Mental Health, Tezpur</li> <li>● Institute of Psychiatry, Goa</li> </ul>	J. & K. Delhi  Bihar Bihar Assam Goa

To provide a relative comparison across all the hospitals in the country, the team rated each of the 32 hospitals personally visited on a 4 point scale from 1 (very poor) to 4 (good). It must be reemphasized that even the hospitals rated 4 have several deficiencies. The rating has largely been based on the quality of service delivery related to the very basic issues of living conditions, food, clothing, maintenance and medical care. NIMHANS has not been included in the rating as it is a multidisciplinary set-up with different patterns of funding and service delivery. However, NIMHANS serves as a good yardstick for comparison of services as it provides an array of services in a multidisciplinary milieu, and many of the hospitals could emulate various aspects of care and service delivery.

When rating was compared to year of establishment, 8 of 15 hospitals were rated poor in the pre-1900 category, 4 of 7 hospitals in the pre-independence category and 3 out of 12 hospitals in the post-independence category. The differences however were not statistically different. Among the monitored hospitals, only 1 of 7 rated poor, compared to 14 of 28 in the non monitored category (DF 2, Likelihood ratio significant at 0.01)



## **Conclusion**

This section reveals the disparities in budget, relative spending, and cost per patient across different hospitals. Despite the increase in budget in many hospitals over the years (Figures 14, 15 and 16), the budget allocation is still so low, and the utilization so variable, that this has not resulted in any appreciable improvements in many hospitals. Although we have not compared hospitals on a state of 'badness' as Mapother did in the 1940's, the same observations hold true and similar problems continue in many of the hospitals even today. Taylor placed the onus of improving of mental health services on the Government. Again, it is now as suitable a time to take for the Governments to take stock, overhaul resources and rechart the course for the next 100 years.

## **PSYCHOSOCIAL REHABILITATION**

### **Introduction**

Persons with chronic mental illness develop disabilities in all spheres of life. This is either due to a lack of acquisition of the skills (due to early onset of illness), or atrophy of skills due to disuse. The disabilities described in the mentally ill are in the area of self care, family roles, social roles, money management, transport, occupation, recreation, and social roles. Disability is much more pronounced in people who are institutionalized for a prolonged period. In an institution there is no need for people to do much for their personal needs as many of these are provided need. This makes an individual become dependent on the system and makes it is difficult for the person to survive in the community, following discharge. Medication alone cannot change this scenario. Current principles of psychosocial rehabilitation need to be applied to improve this situation. It is more evident in case where these patients have to be reintegrated in the community. Families and volunteers' involvement in rehabilitation is an important aspect for the success of rehabilitation. Common programs of rehabilitation currently available are occupational therapy, recreational programs and socialization programs. A variety of settings can be used for rehabilitation, including wards for chronic patients, day care settings, sheltered workshops and half-way homes. Some NGOs have started halfway homes for the mentally ill in the last twenty years.

### **Rehabilitation facilities: Results of the Project**

Rehabilitation facilities in the psychiatric hospitals, covering various aspects such as structure, functions, staff patterns and community involvement were assessed.

#### **Structure**

About 36% of Government mental hospitals have a separate facility for vocational training. About 19% of mental health centers reported that they had sheltered



workshops. During the site visit to the hospitals it was evident that there were no sheltered workshops in any of the hospitals. This illustrates a lack of understanding of the concept of sheltered workshop by the professionals. Occupational therapy sections are present in 63.9% of hospitals. However, untrained personnel in an adhoc manner carried out these activities in the wards. Further, in 61.1 % of the centers it was noticed that only a selected number of patients were attending these activities. In most places these were patients who had substantially recovered and in position to work independently. Such programs cannot be considered therapeutic. Rehabilitation services must focus on skill development and recovery from deficit of patients with amotivation or persistent symptoms.

Awareness among staff in psychiatric hospitals regarding the principles of rehabilitation was poor. This may be one reason why occupational therapy activities remain inadequate. A regular training program for staff across all categories is a priority in all hospitals. Absent posts of occupational therapists and vacancies in most of the hospitals is an important barrier to these services. At this point, it is important to note that there are only few centers in India, which provides training in psychiatric occupational therapy. Even the new colleges providing occupational therapy courses that have recently emerged do not give adequate input in psychiatric occupational therapy. Thus, psychosocial rehabilitation services will remain grossly inadequate unless more centers develop adequate manpower, resources and training are provided.

## **Day Care Facilities**

Such facilities have started to develop in some hospitals. While 7 (19.44%) of the hospitals indicated that they provide day care services, on the teams' visits to the hospital, it was noticed that at least three among these centers do not actually provide day care facilities. The centers providing day care are NIMHANS Bangalore, Mental Health Center Thiruvananthapuram, KIMH Dharwad and IMH Chennai. Thiruvananthapuram has a separate building for Day Care managed by a non-government organization, which works hand in hand with the hospitals. The building is in the campus with a separate entry from outside as well as from the hospital. In this hospital, a majority of the patients are from the hospital and only a few patients come from their home. One of the reasons for poor attendance is inadequate transport. On the other hand, the NGO providing rehabilitation facilities to the KIMH Dharwad caters to very few patients from the hospital. Hospitals providing day care facilities usually had different sections with productive activity. These models are worth emulating in other parts of India.

41.66% of centers reported regular production even though only 36.1% had separate vocational facilities. This is because some form of productive activity is carried out in the wards itself.



## **Rehabilitation wards**

Rehabilitation wards in the mental health centers were present in 8.33% of government psychiatric hospitals. This is important especially in mental health centers where there are a large number of long stay patients. It is advisable to start separate rehabilitation wards for males and females. These wards, as acute care is not needed, require less number of staff. There is an interesting experiment being carried at NIMHANS where the nursing staff have been entirely withdrawn from a chronic ward and the patients are entirely in charge of the ward.

A structured activity program is necessary in such wards to develop skills of daily living, in addition to vocational training. The purpose is to equip these individuals for an independent living and gradually reintegrate them back into the community.

## **Halfway homes**

Half way homes are places where patients are kept before sending them back to the community. These facilities are normally situated outside the hospitals and are usually managed by non psychiatrist mental health professionals. They are more or less like homes, although patients remain there for transient periods, usually upto one year. Skills to live with their families are imparted in these centers. The half way home concept has taken root in a few states like Karnataka, Tamil Nadu and Kerala. Such facilities are usually managed by NGO's. The present facilities are largely for the upper socioeconomic strata. There are only a few residential care facilities for the poor. 87.8% of the mental health centers do not have these types of community care facilities in their vicinity. It is necessary to encourage NGOs to start the same. The family's participation and involvement in the individual's rehabilitation through regular contact with the halfway home staff is encouraged so that the transition from hospital to community is smooth.

## **Long stay and special settings**

There are separate facilities for long stay patients in 47.22% of hospitals. Only seven had separate wards for chronic patients. Chronicity in mental hospitals, which has been discussed earlier, is largely due to inadequate therapeutic input. This can be overcome by converting some of the wards into a long stay facility for those who cannot be discharged due to various reasons. These long stay facilities must have a regular structured program with adequately trained staff. This will ensure a better quality of life for those otherwise would remain along with acutely disturbed patients.

There are no separate facilities for occupational therapy and rehabilitation children in 95% of the hospitals. This is an area of utmost concern. Children should not



be mixed up with adults as their needs differ markedly.

## **Programs**

In 53.65% of the hospitals there were no organized programs for rehabilitation. Combined programs for males and females are present in 5.55%. Separate rehabilitation programs for males and females are present in 33.33%, programs only for males in 2.77% and only for females in 2.77%. Segregation of both sexes has been a striking observation in the rehabilitation activities. However in Day Care centers, both males and females work together as in a normal working situation. It is suggested that all rehabilitation programs wherever possible be mixed. This will help to teach individuals appropriate gender related behaviors. Segregating and isolating by gender often fosters anxiety about interacting with the opposite gender, even among members of their own family.

Most hospitals cater predominantly to psychotics. A small percentage of patients in mental hospitals are mentally retarded adults with behavioral disturbance. 19.44% of centers have a combined program for the mentally retarded and mentally ill. There are no facilities for other problems including rehabilitation for substance abuse. In those hospitals having a de-addiction unit, patients have no specified or scheduled activity.

19.44% of the centers has pre and post assessment of patients attending rehabilitation. Observation and enquiry revealed that these assessments are largely clinical in nature. The staff require to be trained in assessments, including disability assessment. The lack of adequate documentation is one of the outcomes of poor record keeping, lack of awareness and absence of trained staff.

As there are no separate rehabilitation programs in most of the centers, on an average, it can be gauged that only 10 to 20% of the patients have the benefit of rehabilitation services. Most rehabilitation facilities cater to between 20 to 300 patients. Majority of the centers could not provide accurate figures of patients attending the rehabilitation facility.

Only one center ensures employment placement outside the hospital. In 38.88% of the centers, patients are involved in routine hospital work which remains unremunerated and unaccounted. Utilizing patients for hospital work against their will and without any form of remuneration is a gross violation of right to work and right to earn. In most settings, the nursing aides and attenders make patients to do their work for favors like getting coffee or cigarettes.

Incentives are paid in cash in 25% of the mental health centers. These patients are allowed to operate their own accounts and in most of the centers, the hospital authorities maintain patients' accounts.



In about 47.22% of the mental health centers, therapeutic techniques like behavior modification, group therapy, skills training, psychotherapy and therapeutic community approaches are followed for improving functioning of the patients. However there is a lack of awareness among staff regarding these techniques.

## **Volunteers and Community Participation**

Volunteer participation in rehabilitation is very much inadequate. Only 25 (67.6%) of Mental health centers involved volunteers. Even in such places where they were volunteers, they are not being properly utilized. The family's role as a partner in care is not utilized in 95% of the mental hospitals. This is a potential resource which is not being used.

Only one center provides transport facility for patients to attend day care center. Free travel to the rehabilitation center and back must be provided for patients who are attending the day care center. The experience at NIMHANS suggests that such a facility improves day care attendance.

## **Staff pattern**

Separate staff other than occupational therapists and instructors are absent in a majority of the hospitals. Only 2 centers have positions for occupational therapists. Similarly inadequacy of instructors is a matter of concern. This is highlighted by the fact that 75 % of the mental health centers do not have posts of technical instructors. Adequate number of qualified psychiatric social workers and clinical psychologists are not available, even in good rehabilitation centers like NIMHANS.

The overall scenario of rehabilitation in mental health centers is dismal. On the teams' visits to the hospitals, the members found fossilized looms, and rooms with dust and cob webs. In one of the mental health centers, there were 100 looms for woolen weaving and not a single one is being used at present. Poor knowledge and misconceptions about rehabilitation among staff in almost all categories is a fact and immediate intervention is necessary to improve this.

The only center in the whole country having a full range of psychosocial rehabilitation activities is NIMHANS, Bangalore. NIMHANS has separate buildings and staff for rehabilitation. Rehabilitation programs are carried out by the Department of Psychiatric and Neurological Rehabilitation. There is a day care facility which can accommodate 300 patients. There are sixteen different vocational training sections. Pre and post assessments are done regularly with separate case files maintained for each patient. Incentives are paid to all patients based on their performance. There are 34 instructors, 4 occupational therapists (3 posts vacant), 11 nurses, two psychiatrists, two social workers, one clinical psychologist, and nine ward attenders. Transport facility is provided for day care patients. There is regular production and sales, with an annual turnover of Rs 12 lakhs. The Department provides assistance to



community programs, conducts awareness programs, provide technical information for organizations to start rehabilitation facilities, participates in exhibitions and also offers regular job placement and after care services for the patients.

This department is involved in research in various aspects of rehabilitation. This is a postgraduate teaching center and also provides short term courses in rehabilitation. Involvement of different types of volunteers like housewives, NSS students, service organizations like Lions, Rotary, YMCA industries and banks. Rehabilitation programs are governed by the rehabilitation committee comprising of representatives of industries, external experts, heads of other departments, representatives of patients as well as relatives. The Director of NIMHANS is the chairperson of this Committee.

## **Discussion**

Considering the present scenario in mental health centers on rehabilitation, one can conclude that rehabilitation activity is in its rudimentary stages. Very few centers make efforts to improve the facilities. There are certain barriers for implementation of a good rehabilitation program. These are:

- Lack of awareness
- Infrastructure
- Manpower
- Lack of community participation.

Awareness that psychosocial rehabilitation is an effective method in reduction of chronicity and resultant disability is absent even among professionals. Feeling of inability to carry out programs, which are cost effective, is a great barrier. Majority of the mental health professionals do not find time to implement or initiate programs.

## **Infrastructure**

Majority of the mental health centers do not have adequate physical structure, equipment for work, and basic facilities. In those centers, which had facilities, these have fallen to misuse because of poor maintenance. The unused portion of existing buildings in some centers can be utilized to start rehabilitation activities. It is important to start activities, which are relevant to each center like hospital requirements of furniture, vegetables, printing, bakery and clothes.

## **Manpower**

The present study highlights the inadequacies in manpower, especially for rehabilitation. It is necessary that there should be a medical officer / social worker or



psychologist at the class one officer level as a coordinator of these activities. There has to be an appropriately trained staff team in every center for rehabilitation. This can be achieved by training medical officers, nurses, occupational therapists, and nursing aides. Technical instructors have to be appointed in all the centers and adequately trained. There are a large number of ward attenders present in most hospitals. Some of them can be trained in simple activities and can be used for supervising vocational sections. In this regard two years back, HMH, Ahmedabad sent one of their medical officers for training in rehabilitation NIMHANS, Bangalore.

## Community Participation

Almost all hospitals are still closed setups as far as community participation is concerned. There are community volunteers and voluntary agencies, which are interested in participating in the program. It is important to involve them in rehabilitation programs in all the hospitals. Similarly community resources are not utilized in most of the centers. Reasons for not doing this vary from administrative sanctions to personal issues.

Taking these facts into consideration, the following recommendations are suggested for improving the rehabilitation of the mentally ill.

Ideal unit of rehabilitation for 25 patients

## Space

Work shop	15 ft x 30 ft hall
Storage space	10 ft x 5 ft
Work benches	6
Work tables	6
Chairs	6
Office table with draw	1
Light	Five Tube lights(One for store) - Standard size.
Exhaust fans	Two
Flooring	Non slippery
Electrical plug points	
Office for Instructors	10 x 5
Toilets attached	
Drinking water facility	

## Approximate cost for some selected activities

Carpentry unit	Rs 6,00,000-00
Bakery	Rs 10,00,000-00
Candle	Rs 4,00,000-00
Leather unit	Rs 6,00,000-00



**Staff**

Psychiatric Social Worker	1	group 1
Clinical Psychologist	1	group 1
Instructor	1	group 1
Asst. Instructor	1	group 3
Nurse	1	group 3
Occupational Therapist	1	group 3
Clerk	1	group 3
Attender	1	group 4

**COMMUNITY MENTAL HEALTH SERVICES**

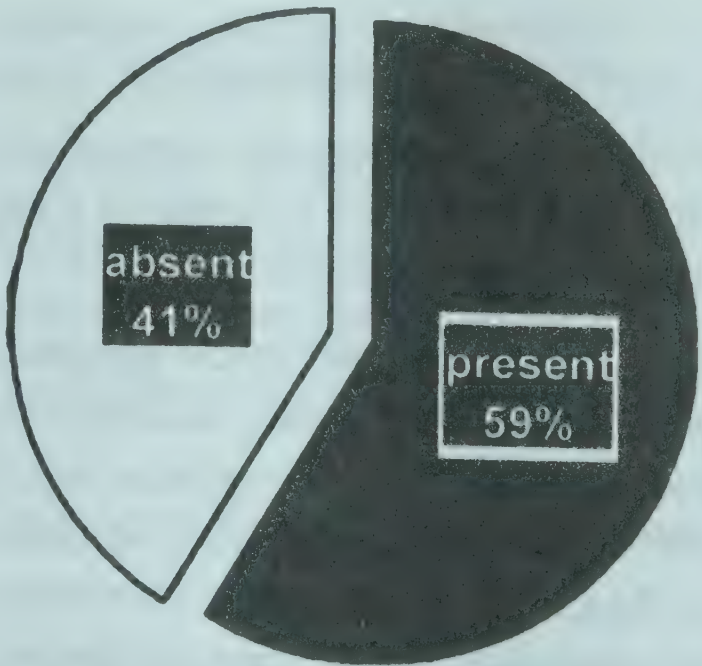
**Introduction**

As reviewed in the introductory chapter the focus of mental health care has shifted from mental hospital towards integrated community based care. Community mental health services include community based rehabilitation programs, school mental health programs, community based rehabilitation for alcoholics, mental health camps and community based drug detoxification camps and extension services.

**Findings of the Study**

**Figure-17. Community Mental Health Activities and Services in Mental Hospitals**

Community mental health services and activities among the 37 mental hospitals in the Country was reported to be present in a varied manner in 59% of the hospitals. These services are organized at the district levels, and include an array of activities ranging from attempts to integrate mental health care into primary health care, to providing mental health services through weekly visits to jails. The National Institute of Mental Health and Neuro



Sciences, Bangalore is the only institution where a separate community mental health unit exists. This unit runs a rural mental health center at Sakalawara village on the outskirts of Bangalore.

Community mental health activities and services in mental health institutions and activities related to The National Mental Health Program (NMHP) were reported by 30% of the mental hospitals. Programs similar to the Bellary District Mental Health Program are in progress at Ranga Reddy in Andhra Pradesh, Nagam, Tiruchirapalli and Sikar Districts of Tamilnadu, Rajasthan, Andhrapradesh and As-



sam. Apart from these six other institutions have been involved in the NMHP in terms of training of primary health care personnel and multi-purpose workers under the mental health care program.

**Table 16. Community Level Activities**

Activities	n=37	%
National Mental Health Program related activities	11	30
Presence of ‘trained’ trainers in community mental health services	17	46
Training for non mental health professionals	20	54
Community out reach program	05	14
Presence of community extension services	12	32

Presence of ‘trained’ trainers in extension of community mental health care are available in 46% of the hospitals. Majority of them had undergone the training program at Bangalore, Central Institute of Psychiatry, Ranchi, or recently at Jaipur.

Inadequacy in extension of mental health services to rural areas as reported by 17 of the hospitals identified shortage of adequate manpower, resources, motivation, and the low priority given to mental health by respective State Governments.

Training and teaching activities for non-mental health professionals is present in 54% of the mental hospitals. A variety of professionals ranging from trainees in psychology, social work, general nursing, as well as primary health care personnel, school teachers and volunteers from non-governmental sectors, have been trained through such programs.

Community out reach programs has been reported from 5 of the hospitals in Tamil Nadu, Karnataka, Andhra Pradesh, and Rajasthan. These include community based rehabilitation programs, school mental health programs, community based rehabilitation for alcoholics, mental health camps and community based drug detoxification camps. Other community extension services were reported in 36% of the hospitals. These extension programs include provision of mental health services by the psychiatric hospitals through periodic visits to jails, institutions for homeless, orphanages, State Institutions for children, women, destitutes, handicapped and mentally retarded. 14 hospitals reported involvement in the provision of mental health services through the general hospitals and district hospital psychiatric units.

The stumbling blocks in extension of community mental health care activities are summarized below. These include issues related to State Health authorities, bureaucratic hurdles, absence or paucity of funds in the hospital budget, non availability of vehicle for community services, social stigma, lack of collaboration and



co-ordination between mental health institutes and other agencies in the community.

### **Impediments in Mental Health Care Extension Activities**

- Prevailing apathy by the government and absence of political will.
- State health authorities not understanding the need for community based activities.
- Mental health services under two Directorates-Health services and Medical Education.
- Bureaucratic hurdles
- Lack of collaboration and co-ordination between the hospital and community agencies.
- Constraints in financial allocation for community based activities.
- Non availability of trained manpower in the existing mental hospitals.
- Social stigma and poor acceptability of services by the public.
- Non involvement of non governmental organizations in mental health care services.

Remedial measures suggested by the hospitals visited include sensitization and awareness programs at various levels, integration of mental health care into general health care, involvement of the NGOs and a shift of focus from mental illness to positive mental health.

### **Suggestions for Organization of Community Mental Health Services**

- Sensitization of planners, administrators in State Health Department.
- Integration of mental health with existing health-care services.
- District Mental Health Program expansion to cover the entire state.
- District mental health team to co-ordinate the community activity in each blocks.
- Provision of specific fund allocation in hospital budget and supporting community services.
- Orientation program on community mental health services at NIMHANS, Bangalore.
- Establishment of rehabilitation and after care facility in the community.
- Provision of vehicle for community care services.
- Focus on mental health of the community than curative aspects of mental illness.

A further discussion on community based services is provided towards the end of this part .



## CHAPTER-8

### PRIVATE HOSPITALS IN INDIA

Mental health care in India was delivered only through government mental hospitals in the pre-independence period. Post independent India saw the advent of mental hospitals and nursing homes in the private sector. The total number of private mental hospitals and nursing homes in India is not very encouraging. The NHRC team visited seven private mental hospitals in order to get a comparative view of the settings vis a vis government mental hospitals. The hospitals covered were from the State of Bihar, Maharashtra, Kerala, Uttar Pradesh and West Bengal. There is one large mental hospital, two are of medium size and four are small.

**Table 17. Private Psychiatric Institutions Visited**

Facilities Visited	State	Bed Strength
Nur Manzil	Uttar Pradesh	60
Nair's Hospital	Kerala	38
Kusumagiri	Kerala	85
Davis Institute	Bihar	200
Kripamayee	Maharashtra	150
Sevak	West Bengal	30
S.H. Hospital	Kerala	800

Two of the hospitals were managed by religious sisters, two by NGOs and three by individuals. The oldest hospital, Nur Manzil Psychiatric Center, was established in 1950 and the youngest, Nair's Hospital, Cochin, in 1984. Nur Manzil Psychiatric Center started as a nonprofit organization and is continuing in the same way.

#### **Structure**

Almost all the hospitals are of RCC building. Three of these have only open wards and no closed wards exist. One hospital has both open and closed wards. Three of the hospitals have only closed wards. In one hospital, chronic wards for long stay patients are present, separated from other cases. Buildings are properly maintained and owned by the hospital.



All are paying patients. However, there is a facility for concessions at the discretion of the management. Living facilities like bathroom, cot, foam mattress, bedside tables, cupboard, lighting, fans and 24 hour water supply is provided in the general category. Special wards have single or double rooms with attached bath.

### **Staff pattern and services**

Psychiatrist's ratio to patient is variable. In the largest private mental hospital, the ratio was 1:200. In smaller facilities, it was 1:20 or 30. However, they are able to provide reasonably good care. One factor may be that the psychiatrists work about 8 hours daily. In most of the centers, they are on call 24 hours. Clinical psychologists and Social Workers are present in all the private facilities even though their number is inadequate. However, the ratio is better than in government centers. Occupational therapists, Laboratory technicians and Staff Nurses are present in most of the private hospitals. In those hospitals run by missionaries, the missionary staff are not paid and a large number of them are in charge of administration and in other key positions. All admissions are voluntary and made by the psychiatrist. Deaths and suicides are low when compared to the government hospitals. Only a few of these hospitals have long stay patients. This is a feature especially in SH Hospital, Thodupuzha in Kerala State and Kripamayee. In other hospitals, duration of admission is for only four weeks. No long stay patients are encouraged.

Private hospitals also face problems of discharge like families not willing to take patients back home. The most common feature in both private and governmental mental hospitals is the lack of family support for the patient. Most of the hospitals visited provide information to all the families on the illness and the need for treatment. In most hospitals, they state that the patients have a right to appeal. Hospitals managed by missionaries and NGO's accept donations in cash and kind. Budgets are adequate.

Casualty and emergency services are present in all hospitals. Common emergency cases are acute excitement, suicidal patients and acute alcohol intoxication. About 90% of these cases are admitted to the wards and rest are treated as outpatient. There are facilities for short stay. Most of the centers do routine investigations. Casualties are adequate in terms of infrastructure and staff.

Daily outpatient facilities are available. Outpatient attendance ranges from 10 to 100/day. Emergency cases are seen in the outpatient. There are separate interview rooms in the OPD with adequate privacy. There is a waiting hall with seating arrangements and toilets are available in almost all the private facilities. This is an area where government hospitals lag behind. Few patients get free medication. All the patients have to pay for consultation, investigation and ward charges. On an average, registration fee is Rs. 50/-. All procedures are charged. OPD facilities are generally adequate.



For inpatients daily activities are scheduled. Ward cleaning and personal care of patients is done daily. Linen is changed once in 2-3 days or weekly. None of the private hospitals provide plinth area/patient. Adequate cots, mattresses, linen and pillows are present in all hospitals. Patients are allowed to wear their own clothes. Smaller facilities have only open ward system. In this regard, Kusumagiri Mental Health Center is a good model. They do not have a single closed facility. Further, they do not restrain patients. All the staff working in the hospital knows this philosophy. Ratio of toilet to patient is 1:2 to 1:5. Most other facilities like fans, cots and chairs are adequate (1:2 to 1:1 to 1:4 respectively).

Privacy for patients is provided in all hospitals. There are vocational activities in the IP wards and staff members actively participate in this. Patient's belongings are kept in the ward on a sharing basis. Record of menstruation is not maintained in some places. Record of weight is maintained.

Shaving of head for males and females exist in very few of the facilities (two) visited. Quarterly anti-lice measures are used. About 90% of the patients are paying. Four seclusion wards have facilities, which are used regularly. Duty rooms for nurses and doctors are present inside the wards (in contrast from many of the general hospitals). Visiting hours are flexible.

## **Diet**

Diet in all the facilities is very good. Average cost per day ranges from Rs 50/-70/. There are separate dietary facilities, in four of the seven, which are well supervised. Diet supply is hygienic and in individual plates. In Nair's Hospital, Cochin, one of the smallest private hospitals, families are allowed to bring their own food for patients. For those who are from long distances the patients are allowed to purchase food from the canteen. In the missionary managed hospital staff members also take the same food which is supplied to the patients. This ensures quality and taste.

In all the hospitals breakfast is served at 6 to 8 am, lunch between 12 noon to 1 pm and dinner from 6 pm to 8 pm. The calorie intake per day is 3000 calories per day on average in all hospitals.

## **Investigations**

All the private facilities have routine blood and urine examination facilities. In two private hospitals facilities for estimation of lithium are available. Laboratories are well equipped in these settings with qualified technicians. In all these private facilities, psychological tests and social work assessments are done. All these investigations are on paying basis.



## **Treatment**

Pharmacotherapy and direct ECT's are provided. In one hospital, they do not use ECT's. Psychotherapy and behavior therapy was present in all the private hospitals visited. Physical restraint and seclusion is practiced in all except two (Nairs Hospital, Kerala and Kusumagiri Mental Health Center, Kerala) for violent patients. In those settings where restraint and seclusion are not used they manage the patients with Pharmacotherapy. The staff does sufficient waiting and close observation. If necessary they provide an additional dose of medication. In the older facilities (Kripamayee), some of the treatment modalities are outdated.

## **Records**

Individual case records are maintained in all hospitals. Confidentiality is maintained and only the treating team has access to the files. In two hospitals computerization of the records is in progress. However, the quality of notes by the psychiatrists is very poor. This is an area, which requires orientation and training. In this aspect, Nur Manzil maintains meticulous records including a good detailed assessment form.

## **Rights of Patients**

Information about treatment is provided to all. Family members are allowed to visit patient in the wards in all the closed set-ups. In the open hospitals, relatives stay as bystanders for the patients. All patients are encouraged to write letters to their homes. Patients are usually not allowed to talk to any social agency personnel. Generally, the private facilities do not have liaison with any type of volunteers or voluntary agencies. Only a small percentage of the staff are aware of the rights of the mentally ill. This is also very patchy and all staff members require orientation program in this area.

## **Service facilities**

Electricity, water, drainage, canteen facility, telephones and library for patients are available in all hospitals. Recreational activities are provided for patients in all private hospitals. There is no Board of Visitors in any of these facilities.

## **Rehabilitation facilities**

Rehabilitation facilities are available in all hospitals except two. Sheltered workshops or day care is absent. Most of the patients have a structured daily program. Occupational therapy is provided in all except one. In one private facility, there is a provision for 100 long stay (indefinite) patients with a well-developed workshop. Products are sold and patients get incentives, which are kept in indi-



vidual bank deposits. However, about 50% of the patients can avail rehabilitation facility at a time. Behavior therapy, family counseling, individual counseling and eclectic approach is followed in these centers. No formal assessment of patients is done in most of these facilities like disability assessment. In one center, they have a separate vocational training section with proper assessment and training with separate staff managing the rehabilitation center.

Volunteers and outside agencies are absent in these private set-ups. Neither are family members or friends actively involved in rehabilitation. No subsidy or disability benefits are provided for mentally ill. In all private facilities there are separate staff for rehabilitation. Occupational therapists are available in most of the places.

Practically no community services are taken up by these hospitals.

Staff training in terms of attending conferences, workshops, seminars and inservice classes is encouraged in private facilities. There are a few court litigations in these private hospitals alleging illegal detention.

Public view of adequacy of care varies from good to very good.

A summary of the various aspects of functioning of private hospital and a comparison with Government hospitals is provided in the accompanying table.

**Table 18. Comparison of function and facilities in Private and Government Hospitals**

Variables	Private Hospitals	Government Hospitals
History	Post independence	Pre and post independence
Management	Indiv/ NGO/ missionary	State Govt.
Structure	RCC. In good condition	RCC. In variable condition
Staffing	Adequate and motivated	Variable in adequacy and motivation



**Table 18. Comparison of function and facilities in Private and Government Hospitals (Contd.)**

<b>Variables</b>	<b>Private Hospitals</b>	<b>Government Hospitals</b>
Admission and discharge	Voluntary admissions	Both voluntary and court
Finance	Income from patients Private funds Donation	State Government
Casualty and emergency	Present	Poorly developed
Outpatient services	All the days	5 days a week
Inpatient services	Present	Present
Dietary and pantry	Good quantity and quality	Poor
Investigation and treatment facility	Largely present	Variable
Rights of patients	Some violation	Gross violation
Medical records	Well maintained	Poorly maintained
Services and facilities	Good to very good	Poor to average
Board of visitors and management	Absent	Variable
Rehabilitation services	Variable	Variable
Community services	Absent	Variable
Staff training	Present	Occasional
Quality of care	Good to very good	Poor to average



## Discussion

All the private sector hospitals visited were of different sizes. The Management also differed like missionary hospitals, individuals, trusts and NGO's. However, in all these set ups, there is a sense of commitment by the management and staff to make the venture successful. As all these facilities are meant for paying patients, standards in hygiene, and other services are maintained very well. Supervision of every detail of day to day management of the hospital is very good. Nursing care is good in all the facilities. This is one of the strengths of private sector.

Acceptability and responsibility is there for all staff and their roles are clear. Along with these facilities there is a sense of competition to maintain excellence in their place.

Buildings infrastructure and hygiene is excellent in some of the hospitals. However care in the private sector is certainly better than in most government psychiatric hospitals. One private facility stands out in terms of open wards and specialty care is the Kusumagiri Mental Health Center, Kalamassery, Kerala State. This facility in all aspects is above average. There is a well-developed child psychiatry unit, separate rehabilitation facility, staff training and community mental health activities. Cleanliness is as good as S.H. Hospital, Thodupuzha, Kerala. This model is worth emulating and can be considered for staff training in mental health area.

## Draw backs

In some of the hospitals, custodial care is practiced, and physical restraint and seclusion is used. There is a need to sensitize all the staff and management about the rights of the mentally ill. In one center, the management was very open. In one hospital, which is one of the oldest, financial information was not given.

In majority of places, the NHRC team was greeted with warmth and hospitality and management and staff were pleased that their hospital was identified for the visit. They were candid in admitting their pitfalls and have expressed their desire to learn more in order to improve care.

Apart from these issues, the overall picture of these private hospitals is very good. Whether all the private hospitals in the country have the same standards is unclear. They need encouragement to grow further. If one compares the facilities with the existing government facilities, there is a vast chasm between these two. The government facilities are burdened with problems of infrastructure, poor maintenance of buildings, inadequate or poorly trained staff, poor standards of service, very poor hygiene and absence of a good work culture. These facilities generally lack a sense of commitment.



In India, there is a need to encourage private facilities. In this regard, the present Mental Health Act 1987 is not very friendly towards the private facilities, an area the NHRC must take serious note of. Many of the private hospitals and nursing homes are apprehensive regarding the implementation of the Mental Health Act 1987. The Mental Health Act, 1987, needs to be amended to encourage the private sector to enter the field of mental health. In this regard, the Indian Psychiatric Society has taken the initiative, by arranging a series of workshops in different parts of the country to obtain information regarding difficulties faced by the private sector.



# CHAPTER-9

## GENERAL HOSPITAL PSYCHIATRY UNITS

### Psychiatry Department in General Hospitals

As discussed in the introductory chapter, the General Hospital psychiatry movement indicated a new wave in the development of more accessible psychiatric services in our country. Prof. N.N. Wig, one of the senior psychiatrists recognizes that this an important milestone in the development of psychiatric care. The first such unit was established in 1933 at Calcutta, the second in 1938 at Bombay. However the real spurt in setting up of these units occurred during the decade of 1960 and thereafter. Most of these units were started in collaboration with neurology and named as Neuro- Psychiatric clinics. These units have a number of advantages namely:

- They are situated right in the community and are easily accessible and approachable.
- General hospitals do not carry the stigma or fear of being labeled ‘mad.’
- Families could easily visit and family members could stay along with the patient. They could learn to take care of the patient.
- There are no legal restrictions on admissions / discharges
- Easy referral and proximity of other medical departments makes the management of associated physical ailments easier.
- More patients with minor mental disorders can obtain care.
- Liaison with other departments can facilitate a positive change in the attitude of non- psychiatrist doctors. Integrated care can also encourage and facilitate other medical professionals to identify mental health problems in their patients and handle or refer them.
- Psychiatry would be less isolated and gradually could rejoin the main stream of medicine.

“With the coming of general hospital psychiatry units, psychiatry has come to age in India. It has broken the walls of mental hospitals to become a large community based mental health movement” ( N.N. Wig).

Currently these are more than 200 psychiatry units of varying sizes with a bed strength of 2 to 200 with an average of 20 beds. There are about 3000 beds available



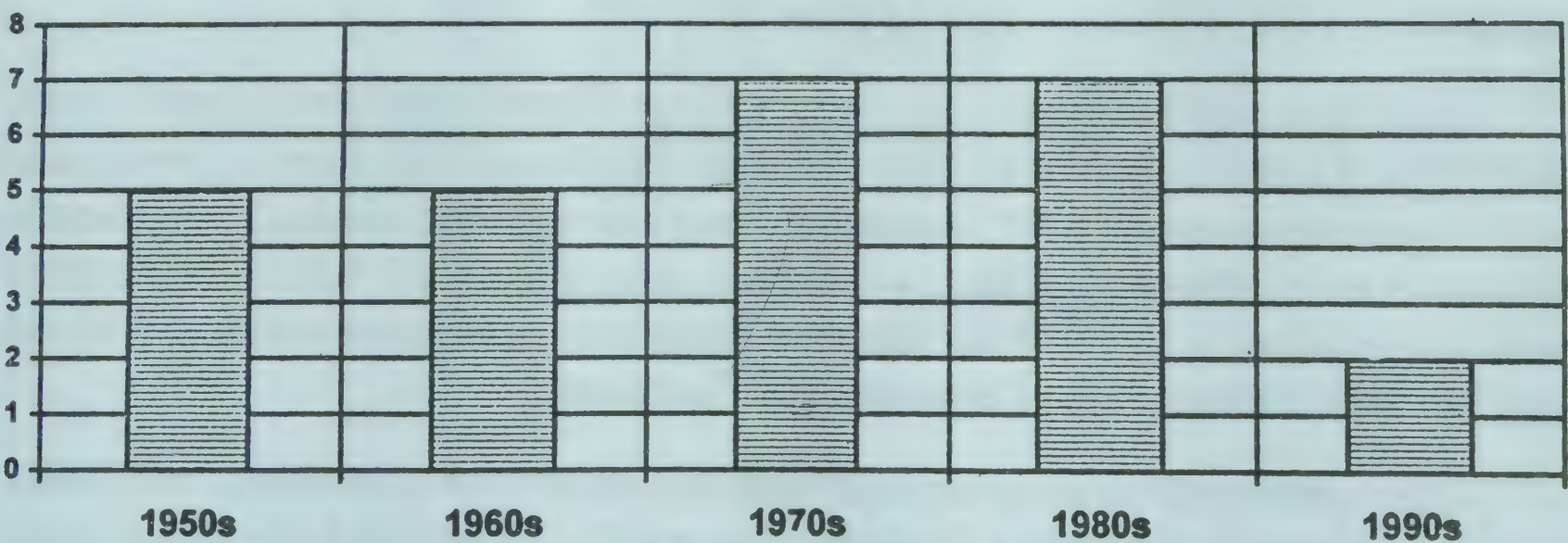
in India in such departments. An ideal General Hospital Psychiatry Unit offers daily out patient services, liaison consultation to all the sister-departments of that hospital and that of near by hospitals. A GHPU attached to a medical college hospital is expected to offer teaching and training facilities for both undergraduate and post graduate students of different disciplines in that college, nursing colleges, medical and paramedical personnel of Health and Family Welfare Department. Many mental health professionals prefer to work in this set up and enjoy good job satisfaction.

## THE NHRC PROJECT VISIT TO GHPU’S

### Introduction

Although the primary focus of the NHRC Project was on Quality Assurance in the government run Mental Hospitals in the country, the scope was extended to include general hospital psychiatric facilities. 87 units were contacted by mail and requested to fill up a proforma (briefer than those for the mental hospitals) pertaining to issues of structure, function and service delivery. 27 proformas were returned [response rate 27/87, (31%)]. Personal visits were made to 23 general hospital psychiatry units, including the Department of Psychiatry, King George Medical College, Lucknow, Cooper Hospital and the MIMH Sassoon Hospital, Mumbai, were visited. This section on GHPU’s presents information based on the information received through the proformas (excluding the latter 3 hospitals which did not send the filled proforma). A list of the hospitals from whom proformas were received is provided (Appendix 3 ).

Figure : 18





## Background Information

Of the general hospitals reviewed, the majority were set up in the 1970s and 1980s (Figure 18). Four each were in Tamil Nadu and Karnataka, three each in Madhya Pradesh, Maharashtra and Punjab, two each in Gujarat, Kerala, West Bengal, and one each in Assam, Bihar and Uttar Pradesh.

Two of the Departments of Psychiatry are over 50 years old (Government Medical College, Chennai, and the Seth GS Medical College and KEM Hospital, Mumbai). The Goheen Psychiatric Center, Department of Psychiatry at the Wanless Hospital Miraj, has been functioning since 1955. It started initially with 8 inpatient beds but by the middle of 1956. In contrast, two of the departments came into existence only in the 1990's (in the Adichunchunagiri Medical College at Tumkur in Karnataka, and in the Raja Muthiah College at Arcot in Tamil Nadu). Except 5 units which were established between 1947 to 1957, the rest have established in 1960s, 1970s, or in 1980s.

There are no separate departments of psychiatry in Jabalpur and Indore, and the staff function under the Department of Medicine. Although psychiatric services at the MGM College at Indore have been formalized only recently, the unit in Jabalpur has been functioning since 1974!

## Inpatient Services

No inpatient admissions are made in at least 3 of the facilities (e.g. Pataliputra Medical College, BSM College Bankura - Departments established in 1978). Lack of trained manpower is cited as the commonest reason for not starting inpatient services. However it is creditable that in some of the colleges (e.g. BMP Medical College, Bijapur), despite the lack of adequate staff, annual admissions over the period from 1992 -1996 have ranged from 60 to 370.

Sadly, in one of the oldest Departments of Psychiatry (at the Government Medical College, Chennai) there is no separate inpatient admission facility for psychiatrically ill patients. In addition to Chennai, there are no separate wards for psychiatric patients in an additional 7 of the 24 facilities, apart from the 3 which do not have inpatient services. In the Victoria Hospital, Bangalore, a separate building with 45 beds has been allotted to the Department of Psychiatry.

In the centers which have separate beds designated for psychiatry, beds range from 15 to 107 (e.g. in Calicut). Colleges/ General Hospitals which have large inpatient psychiatric sections include Father Muller's Hospital in Mangalore (65 male, 35 female), KEM Hospital (36 male, 16 female), Stanley Medical College (45 male, 30 female).



Mean duration of stay is 13.67 days and ranges from 3 to 30 days across different centers. Free psychiatric medication is provided in 17 (63%) of the centers.

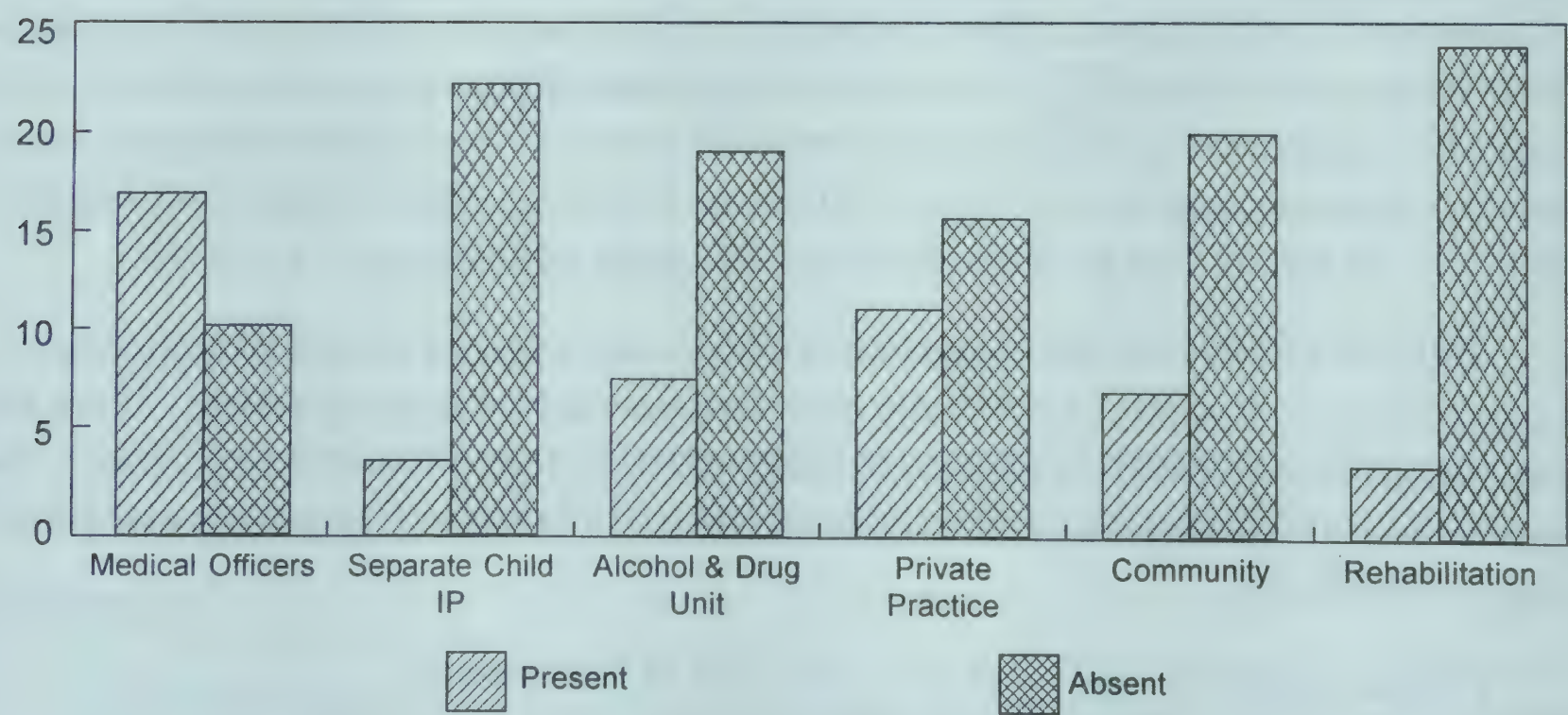
Admissions

Total admissions across the 27 centers each year have been relatively constant over the period between 1992 and 1996, accounting for about 9300 admissions each year.

Special facilities

Separate facilities for inpatient admissions for children exist only in 3 of the 27 facilities (11.1%). In some places, e.g. in Thrissur and Calicut, children are admitted into the female ward.

Figure 19. Facilities available in general hospital/medical colleges (n=27)



Separate facilities for De-Addiction are present in 8(29.6 %). Beds for deaddiction range from 5 (in Ludhiana, Amritsar and Patiala and Bangalore) to 56 (in Father Muller’s Hospital).



## Outpatient Services

Daily outpatients are run in all the colleges. Attendance at OP varies from 10 to 310 with an average of 67 patients (data from 19 centers). While emergency services are available in 80 % of the hospitals, in most places these are managed by the casualty medical officers.

## Staff

There are 2 qualified psychiatrists each in the Medical Colleges at Baroda, Patiala, Bijapur, Jamnagar, Bankura, North Bengal, Dhanbad and Amravathi. Raja Muthiah College in Tamil Nadu, Adichunchunagiri College in Karnataka, and Stanley Medical College in Chennai, TN have 3 psychiatrists each. Medical College Psychiatry Departments in Kerala are well staffed (6 psychiatrists in Thrissur with a 23 bedded facility, 9 in Calicut with a 107 bedded facility). There are 7 psychiatrists in KEM Hospital (90 beds) and 8 in Father Muller's Hospital (100 general psychiatry beds). There is only one qualified psychiatrist in the hospital at Bangalore, with two vacancies. Overall, psychiatrist: inpatient ratios vary from 1: 4 to 1: 10 in the facilities reviewed.

The lack of trained psychiatric nurses is glaring. Only 6 (22 %) of the facilities have trained psychiatric nurses. Where they exist, their ratios to patients range from 1:20 to 1:107. While some of the psychiatric nurse posts lie vacant in 5 of the facilities it is remarkable that in 15 (56 %) of the institutions, such posts do not even exist! Even the number of general nurses posted in most of the facilities appears inadequate, ratios varying from 1:10 to 1:90. Some hospitals without inpatients have no attenders. In others that do, attender to patient ratio varies from 1:4 to 1:40.

Only 14 (51.9%) of the centers have sanctioned posts of clinical psychologists. Among these, in 6 centers (22%), the only sanctioned post is lying vacant. There are no posts of social workers sanctioned in 7 (25.9 %). In the other 20 centers, the number of trained social workers ranges from 1 in 15 centers, 2 and 3 in one center each respectively.

Private practice is allowed in 11 (40.7%) of the centers.

## Other services

Some form of community activity is present in 7 (27.9 %). Rehabilitation facilities are provided in 3 (11 %).

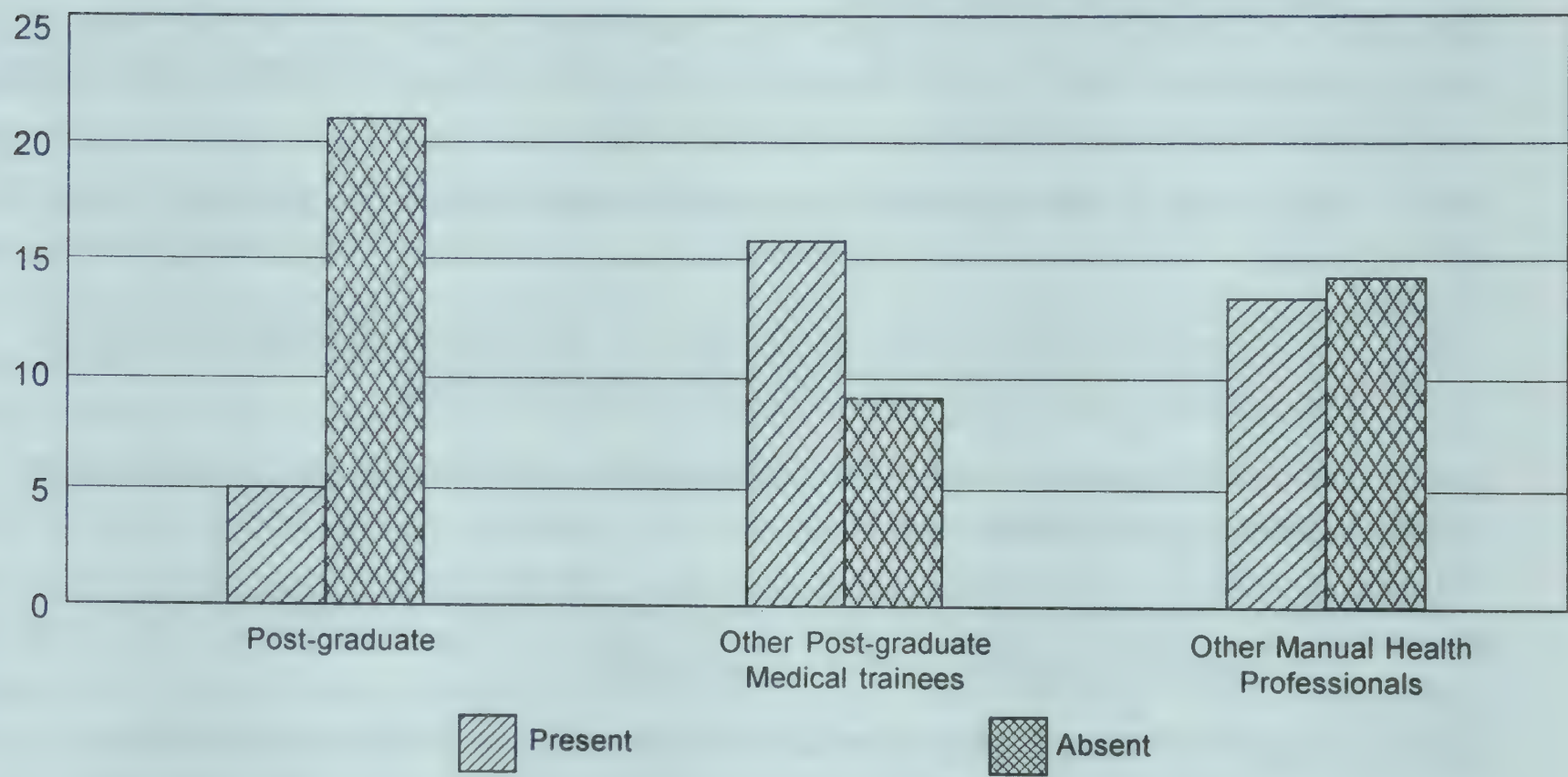
No suicides or homicides have been reported in any of the centers. Total deaths across all the centers together are about 1 to 2 per year, usually related to physical complications.



### Training and Research

Undergraduate training is provided in 22 (81.5%) of the centers. Postgraduate training in psychiatry (for MD Medicine, MD Pediatrics etc is imparted in 16 (59.3%). Postgraduate courses in psychiatry were being offered in only 5 (18.5%). Only 13

**Figure 20. Training in general hospital / medical colleges (n=27)**

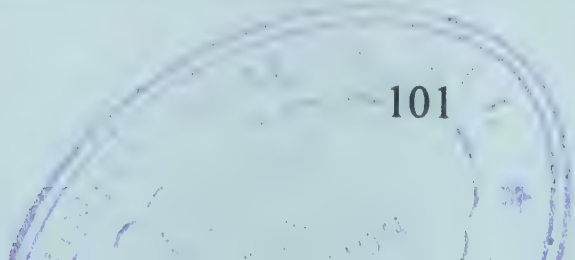


(48.1%) offer some kind of training for paramedical staff. Most of the research publications in psychiatry have been from general hospital psychiatry units.

### Summary

The following are the lacunae, constraints and limitations of general hospitals psychiatry units.

- Full team of mental health professionals may not be present. In sizable, number of units, only one psychiatrist is available.
- Inadequate resources to run the out patient and inpatient sections.
- Non - availability of adequate supporting infra - structure.
- Non - availability of free medicines



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- Beds are distributed through out the hospital, they are not located in one single ward.
- Frequent transfers / changes in the nursing staff, ward staff.
- No basic facilities are available for the attendants of the patients.
- Step-motherly attitude of medical superintendent and other administrative staff towards the unit and the patients.
- The psychiatrists may not have 'specialist' cadre and has to work like a general duty medical officer.
- Absence of modified ECT, special investigations, rehabilitation facilities which are required for psychiatric patients.
- Objection of other patients and staff to admit psychotic patients in the ward.
- Non – availability of emergency care for psychiatrically ill patients in the casualty section of that hospital round the clock.
- Over - diagnosis of cases by other doctors and specialists in the hospital and wrong referrals.
- Associated physical problems and diseases in the mentally ill – not accepted by doctors of other departments.
- Psychiatrists and other mental health professionals may experience 'stigma' and a kind of rejection by others colleagues. This is due to ignorance, wrong attitudes.
- Unwanted and undesirable staff are posted to psychiatry to the psychiatry departments.

Inspite of all these problems, it is heartening to note that the number of psychiatry departments is increasing year by year. National Mental Health program of India has recommended to establish psychiatry department in every district in the country. In the district mental health program, district hospital psychiatry unit is the center of all community based mental health activities. It should have full team of mental experts and should have 20 bedded inpatient unit. It should work for all levels of prevention. In the district of Bellary of Karnataka State, a model project was carried out during 1984 to 1990. The logistics and cost effectiveness of running a district mental health program were worked out. Now Govt. of India has launched a district mental health program in states like Assam, Andhra Pradesh, Rajasthan, Tamilnadu, Himachal Pradesh and planning to extend it to many more states.

States like Tamil Nadu, Kerala, have already established psychiatry units in all most districts. Indian medical council has made it compulsory for all the medical



colleges to have department of psychiatry and to train the undergraduates in mental health care. In states of Karnataka Maharashtra, specialty cadre is offered to psychiatrists and they have to work in district hospitals or any major hospital with 200 beds.

Thus general hospital psychiatry departments appear to play a major role in the organization of mental health care services with community and offering quality care to the patients.

It was envisaged that the general hospital psychiatry movement would see a significant shift in the locus of psychiatric services from the mental hospitals, and ensure better and more accessible care to the community. The impressions gained from this sample of general hospital psychiatry services do not quite substantiate this belief. The lack of inpatient services despite departments of psychiatry being established several years previously, and the lack of separate inpatient facilities even in well staffed psychiatric departments, the total lack of other mental health professionals are cause for great concern. If it is the stigma against mental illness that is being faced in the community, there appears a stigma against development of adequate psychiatric departments for service delivery in medical colleges. The status and low priority for service delivery and low allocation of budgetary provision appear to be partly responsible for this lack of growth of general hospital psychiatry services. However apathy among the professionals themselves seems an important cause, as in some places, despite constraints of staff and funding, it has been possible to develop good psychiatric services. Centers with comprehensive psychiatric facilities however few, e.g. KEM Hospital, Father Muller's Hospital, Stanley Medical College are good examples of how effective general hospital psychiatric services can be. Liaison with other departments to provide psychiatric care for emotional problems in patients with cancer, stroke, arthritis, tuberculosis, HIV, obstetrics, etc, need to be developed.



# CHAPTER-10

## INVOLVEMENT OF COMMUNITY IN THE MANAGEMENT OF MENTALLY ILL

The essential features of community involvement in the care of mentally ill are

Early identification of cases. Initiation of treatment which is easily available, accessible and affordable by the patients and their family members.

Supporting the family to manage the patient at home.

Habilitation and rehabilitation of the patients in the community using the available resources.

Ensuring supportive services to integrate the patients in the community so that they can lead an useful life.

### **Early identification and treatment by general health care personnel**

Earlier the treatment better is the outcome. 75% of our patients live in villages where services of mental health professionals are not available. The patients have to be identified and managed by primary health care personnel. Training of all types of PHC personnel in mental health care: there are 15,000 primary health centers, one lakh subcentres, 10,000 general hospitals in the country. 35,000 doctors, 2 lakh nurses, 2 lakh health workers work in these centers. On the average, one PHC for every 30,000 population, one doctor for every 3000 population, one male and female worker for every 3 to 5000 population. If they are trained and assigned simple tasks, they would be able to identify and initiate treatment for mentally ill in a cost effective manner. The experience of NIMHANS, Bangalore (during 1981 – 1990) of training more than 1500 health workers and 800 doctors for a short period in mental health care, Bellary district mental health program (1984 – 1990) Raipur Rani (Haryana state) experience of integrating mental health component into PHC system (1975 to 1980) showed that PHC doctors and health workers can manage majority of mentally ill in the community. Regular supply of free essential drugs, support and monitoring by mental health professionals and administrators ensures the quality of care. National mental health program of India has recommended that basic mental health care has to be delivered through PHC system.

### **General Practitioners**

They are more than one lakh trained doctors in the private sector and they are popular and are approached for health care in towns and cities. They are family



physicians for many of their clients. G.Ps who underwent training in mental health care at Bangalore, not only treated mentally ill but also got involved in training other G.Ps in mental health care. Similar programs conducted in Vellore and Hyderabad showed that G.Ps could be involved in the care of mentally ill without stigma.

**Family :** Families are the biggest resource in the management of mentally ill. But they have to be educated, supported in this task. The credit of involving family members in the care of psychotics goes to Dr. Vidyasagar of Amritsar. He encouraged them to stay in the hospital premises along with their patients and look after them. Similar attempts were made at C.M.C. Vellore, NIMHANS, Bangalore patients who stayed with their families, recovered fast and got rehabilitated quickly; relapses were less. Realizing these benefits, in majority of the psychiatric departments in general hospitals, patients are always get admitted along with one or two family members or relatives. These people learn to medicate the patients, look after their needs, observe the improvement. They get educated, give up wrong beliefs and practices. They go back with the recovered patients and manage them well at home also.

### **Extension clinics and mental health camps:**

Periodic, regular Clinics in taluk or district places by professionals, help patients to receive treatment nearer to their living places. This cuts down expenses which are required to reach mental hospitals. These clinics or camps help in increasing awareness among people about mental disorders and treatment facilities. NIMHANS is successfully conducting 5 such extension clinics which draw a patient crowd of 200 to 300 patients to each clinic, during the last 20 years. Mental hospitals at Thane, Pune, Ratnagiri, Hyderabad, and at a few other places are running such clinics

Detoxification camps held in western Rajasthan (Jodhpur) to treat opium addicts, de-addiction camps organized by TTR foundation in Madras for alcoholics are reported to be successful in organizing such services in the community.

### **Home Visits by Psychiatric Nurse**

A psychiatric nurse visits the patient's house, gives medication, and guides the family members in the re-integration of the patient into the society. NIMHANS experience has shown that one nurse can take care of 30 to 35 psychiatric patients in the community.

### **Non – Governmental Organizations**

NGOs play an important role in the care of mentally ill in the community in the following manner.



- a) Educational activities
- b) Identification and referral of patients
- c) Support to the family members
- d) Organization of extension clinics, camps,
- e) Establishing and running halfway homes, day care or night care centers, vocational and rehabilitation centers.
- f) Organize mental health clubs to promote mental wellbeing.
- g) Helping in the discharge of patients from mental hospitals.
- h) Finding placement for improved patients.

Amend, Medico – Pastoral Association, Friends of NIMHANS, Richmond Fellowship, Family Fellowship Foundation in Bangalore, SCARF, SNEHA, in Madras, Abhaya in Trivandrum, Sanjeevini in Delhi are a few examples.

NGO's can also act as pressure groups and watchdogs to protect the human rights of the mentally ill and their families.

### **College student volunteers**

NIMHANS, involved NSS students to interact with chronic patients and teach them living and socializing skills successfully.

### **Lay Counselors**

Lay volunteers from different section of the society can be trained to work as counselors. They counsel persons with minor mental health problems, psychotics and family members to improve their coping skills and maintain a better quality life. Prasanna Counseling Center, Helping Hand, Viswas in Bangalore are a few examples.

### **Community Leaders**

The study done in Bangalore in which 20 village leaders were given an orientation training in mental health, showed that these trained leaders could effectively identify and motivate the patients and their family members to reach the psychiatric services for help. They understood and in turn educated them about the importance of regular medication and follow up. They got rid of their unscientific fears and beliefs about mental disorders.

### **Traditional Healers**

Several studies have revealed that traditional healers are approached first for



help by mentally ill and their family members. Since traditional leaders do not blame the patients for the illness, but blame external forces (like evil spirits, bad stars and planets are black magic) for the same and treat the patients as victims of these forces, this is no stigma. Many leaders are good counsellors and help to sort out psycho – social and financial problems. They can be encouraged to be referral agents so that they persuade the patients to take medicines and other modern methods of treatment. They can be persuaded to give up painful, harmful, treatment techniques like beating, branding, starving the patients. Attempts to involve traditional leaders in the care of mentally ill yielded mixed results in Bangalore. This has to be replicated in other parts of the country.

## **Indigenous (Indian) Systems of Medicine**

Indian system of medicine like Ayurveda, Homeopathy, Siddha, Unani, Native Medicine, Nature Cure have their own explanations and treatment methods for mental disorders. Ayurvedic research unit of NIMHANS Bangalore, has experimented with a number of treatment methods including Ayurvedic drugs in the management of mentally ill and has shown that they are beneficial. There are more than 2.5 lakhs Ayurvedic doctors. 1500 Ayurvedic hospitals in the country. Doctors who practice other systems of Indian medicine are in large number. They can be involved in the management of mentally ill in the community.

## **Mass Media**

News papers and periodicals (print media) Radio, Doordarshan Kendras, Cinema Theatres, Folk Media's have to be involved in mental health education. They can help in the removal of fears, stigma about mental disorders. They inform the family members and patients about the availability of mental health services. They increase the awareness of the community regarding the needs of mentally ill and protect the rights.

Thus there are many resources in the community which have to be tapped. They all can be involved in identification, treatment, rehabilitation, and prevention of mental disorders. They can join hands to protect the rights of mentally ill and to improve the quality of life. All these resources have to be brought under a 'NETWORK SYSTEM' which can monitor, evaluate and support the services.

## **Recommendations**

It is mandated under the Indian Medical Council that there should be Departments of Psychiatry in each Medical College. However, it is important that these departments are developed in order to ensure adequate service delivery.

- All colleges must have inpatient psychiatric services, preferably situated



on the ground floor.

- Psychiatric patients must be admitted in separate wards
- Psychiatric units must be adequately staffed. This includes appointment of personnel including trained psychiatric nurses, psychiatric social workers and clinical psychologists.
- More departments of psychiatry need to start or strengthen their teaching programs for postgraduates in psychiatry. Training of other mental health professionals as well as for postgraduates in other medical specialties needs to be strengthened.
- Undergraduate psychiatry in most places has remained confined to discussion in numerous workshops and has not led to the envisaged programs. Important lessons on integrated teaching of psychiatry can be learned from private institutions such as the Christian Medical College, Vellore and the St. John's Medical College, Bangalore.
- Attention must be paid to develop comprehensive psychiatric services, including community mental health services
- Linking mental hospitals and general hospital psychiatry units will improve academic inputs into the former and widen the scope of services of the latter.



# CHAPTER-11

## MENTAL HEALTH SERVICES FOR THE NEW MILLENNIUM - WHICH WAY TO GO?

### Introduction

The National Human Rights Commission's project on Quality Assurance in Mental Health Care has thrown light on the current status of mental health services in the country with a special focus on the prevailing conditions in all the mental hospitals and few of the general hospitals psychiatry units. In the light of the findings of the project a set of recommendations to improve the conditions in mental hospitals have been made. If implemented appropriately, these recommendations can transform the mental hospitals in the country from custodial to therapeutic institutions. The various components of the project namely the mail questionnaire survey, field visits to mental hospitals by investigators interaction with various categories of personnel during field visits and the workshop at NIMHANS for the personnel from different mental hospitals are already beginning to have an impact on the quality of services. For example, the project has contributed to increased awareness about mental health problems and conditions in mental hospitals among health administrators and key persons involved in health policy formulation, financial management of health programs and service development in many states. Decisions about improving of living conditions of patients, adding of new amenities etc. are already being taken. Few states have identified co-ordinators for improvement of programs while others have constituted monitoring committees. However, even with such transformation mental hospitals can play only limited role in responding to the wide variety of mental health problems that exist in the country. Moreover all over the world has been a shift from care of patients in mental hospitals to patterns of care which leave the patient more integrated with the social environment from which he/ she comes. There is a need to develop a comprehensive and well-integrated network of mental health services in the country.

This chapter gives an outline and suggestions for further development of mental health services. The focus of the outline is on moving mental health care presently centered in the mental hospitals to care embodied in a more comprehensive broad based and community oriented service.

It must be realized that there is a dire need in the country for human resources, variety of facilities as well as financial and other resources required for the development of mental health services. When there is a service lack of resources for health in general, it is often mental health care which receives the lowest priority. The



magnitude and severity of mental health problems in the community and the cost of not treating them appropriately are enormous.

The overall objective of developing comprehensive mental health services should be to reduce the level of disability caused by mental disorders by improving significantly the treatment and care of persons with mental disorders. The based human rights of persons disabled by mental disorders must be respected.

### **Enlarging the Scope Of 'Mental Health Services'**

'Mental health' is an essential part of health. The World Health Organization (WHO) defines health as a "state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". The National Mental Health Programme for India approved by the Central Council of Health and Family Welfare in 1982 envisages "application of mental health knowledge in general health care and social developments". It is generally understood that mental health deals with activities related to the development of psychosocial skills and knowledge as well as to functional and psychosocial aspects of health care, which can facilitate and improve the functioning of general health care systems. Comprehensive mental health services should include all measures to promote mental well being along with treatment and rehabilitation of persons with mental disorders. According to the World Health Organization, promotion of mental health is primarily concerned with the optimal psychosocial development of human beings. It is a process which aims at enabling people to develop and increase control over their health in general and mental health in particular and at the same time improving it. It also refers to the value which individuals and societies give to mental health and functioning. It implies a great deal of attention to overall social development as well as to psychosocial aspects of health and of health care.

Prevention of mental disorders deals with identifying and taking appropriate action to eliminate the causes of mental disorders, many of which have already been identified. Suicide prevention programs, prevention of brain damage due to head trauma or infections and correction of iodine deficiency to prevent mental retardation are examples.

Mental health services should aim to detect all mental disorders in the community as early as possible and provide appropriate care and treatment as close to the homes of those suffering from these disorders as possible. Persons with chronic disorders should be rehabilitated to achieve optimum social integration. It is now widely agreed that mental health care should be integrated with the rest of the health program and basic training in mental health care should be provided to all health workers. Systematic support and supervision should also be provided to all health workers involved in mental health care. It is necessary to understand that the health



workers are usually over burdened with many tasks and care is needed to avoid creating an unbearable burden on general health workers while integrating mental health into their routine work. Standard guidelines for the management of mental disorders frequently seen at primary health care settings should be developed. Essential drugs as well as other forms of therapy such as psychological and psychosocial interventions should be made available.

When the scope of mental health services is enlarged beyond just the treatment of mental disorders to include promotion of mental health and prevention of mental disorders, multi dimensional and multi-disciplinary involvement and interventions will be required. Inter-sectoral collaboration and active community participation is also necessary.

## **Principles of Mental Health Policy And Service Development**

While planning mental health services in the country for the future, several principles should be kept in mind.

These are as follows:

### **A. Comprehensiveness**

A range of facilities and services aimed at different types of disorders and different types of population should be developed. Services provided in mental hospitals and general hospital psychiatry units should be diversified and a variety of community based alternatives to hospitalization should be restricted to only to those who absolutely require it.

### **B. Decentralization**

Services should be decentralized and made available within easy travelling distances of patient's homes. This requires the designation of precise geographical spheres of responsibility for mental health services and necessitates the creation of services for defined populations.

### **C. Access to Basic Mental Health Care**

Every one in need should have access to basic mental health care which is also affordable. Mental health care should be available on a voluntary basis as health care in general. Such care should also be culturally appropriate.

### **D. Continuity of Care**

Persons suffering from long term mental disorders require a variety of supports and services on a continuous basis to function within the community. There should be provision for continuous care for those who require it.



## **E. Least Restrictive Mental Health Care**

Persons with mental disorders should be provided with the least restrictive type of care. Isolation in cells/isolation rooms should be eliminated. Consent should always be obtained before any type of interference (such as diagnostic procedures, use of drugs, ECT etc.) with a person with mental disorder is carried out. It must be realized that persons with a mental disorder are generally able to make their own decisions. In case a person with a mental disorder is found to be unable to consent there should be a surrogate decision-maker authorized to decide on the patient behalf and in the patient's best interest.

## **F. Community Participation**

The involvement and participation of the community is essential in policy and service development in the area of mentally health as is for health in general. Various mechanisms should be developed for people to express their opinion. Community attitudes towards mental illness may have to be assessed and appropriate awareness programs may have to be introduced. Policies and services should respond to the specific needs of different regions and to the different needs of individual groups within a community.

## **G. Inter Sectoral Collaboration**

Comprehensive mental health promotion programs and mental health care services within community based programs can never be successfully provided by health services alone or by the community alone. Like many other programs inter-sectoral collaboration is a necessity for mental health care. Various sectors such as education, social welfare, police, judiciary as well as non-governmental organizations must collaborate with the health sector in a co-ordinated manner. There can be mental health components in programs of other sectors too, for example, various development programs.

## **Future of Mental Hospitals**

With more than 20,000 beds (in Government and private psychiatric institutions combined) the mental hospitals in the country constitute a major component of the total mental health care infrastructure. The NHRC project has reviewed the current status of mental hospitals and has made far reaching recommendations to improve these hospitals. The successful implementation of the recommendations will depend on the decisiveness and willingness on the part of competent authorities as well as resource availability. Human resources in the form of interested and committed personnel willing to work in mental hospital settings and who can provide technical knowledge, expertise and leadership are also required for the transforma-



tion of mental hospitals. Public Interest Litigation and judicial intervention have to some extent, already initiated the process of mental hospitals reform. This process will now have to be sustained and further expanded.

The transformed mental hospitals will continue to have a major role in mental health care. They will have to care for the 'old' long-stay patients, many elderly patients who cannot be discharged or accommodated elsewhere, a number of 'new' long stay patients and patients sent by the Courts. With starting of active out patient and follow-up services as well as community based extension services the stigma of mental hospitals will hopefully decrease. Admitting patients with their family members to 'open' wards will increase family involvement, decrease period of hospitalization and reduce stigma. Mental hospitals will remain an essential part of psychiatric services. They will form one part of mental health facilities in a network of alternatives providing diagnosis, treatment and rehabilitation services for the community.

## **COMPONENTS OF COMPREHENSIVE MENTAL HEALTH SERVICES**

### **A. General Hospital Psychiatry Units**

The genesis, evolution and current status of psychiatry units in general hospitals has been discussed in an earlier section. All major general hospitals all over the country, including district level general hospitals in the governmental and private sectors should start departments of psychiatry, with small inpatients units wherever needed. The lacunae identified in the current units should be rectified. Full fledged psychiatry departments should be started in all medical colleges.

### **B. Community Based Mental Health Services**

The National Mental Health Program of the Government of India, as early as 1982 had highlighted the relevance and significance of starting community mental health programs at the primary health center level all over the country. Models for starting such programs have been developed and field-tested. Such programs have also been shown to be feasible at a district level. The District Model of extending mental health services to the rural community as well as to the under privileged sectors of society in Bellary District of Karnataka State is currently being replicated in many other states such as Andhra Pradesh, Tamil Nadu, Rajasthan, Assam etc. Such district programs should be implemented in all districts in India gradually.

### **C. Programs by Non-Governmental Organizations**

It is only in the recent past that non-governmental organizations have started paying attention to mental health related programs and activities. A variety of inno-



vative initiatives have come up in different parts of the country started by NGOs of various sizes and backgrounds. They have also initiated a variety of care and rehabilitation programs. NGOs should continue to contribute to the development of a network of comprehensive mental health services.

#### **D. Private Sector**

Various types of services, which include private mental hospitals, long-term, care homes, half way homes, hospitals, nursing homes, clinics and consultation rooms have come up, largely in urban areas. More such facilities are likely to be started in the private sector. Sections of the population who can afford to use private sector facilities are steadily growing.

#### **E. Rehabilitation Centers**

There is a need for starting various types of rehabilitation facilities such as day care centers, sheltered workshops, facilities for partial hospitalization, vocational and occupational therapy centers, half-way-homes etc. These facilities are required in governmental settings (including most of the existing mental hospitals), private sector and non-governmental/voluntary sectors.

#### **F. Services For Special and At-Risk Populations**

Populations in need of specialized care and facilities consist of children and adolescents, the aged, certain underprivileged sections of populations in remote, rural and tribal areas etc. Similarly, certain populations have higher risks of developing specific categories of mental disorders e.g. industrial workers, alcohol use related disorders, women at risk to specific forms of abuse and violence, populations at risk for developing conditions such as AIDS, etc. In future, planning of mental health care services, the special needs and special populations will have to be given adequate priority.

#### **G. Involvement of Professional Bodies**

Professional bodies in the field of mental health such as the Indian Psychiatric Society, Indian Association of Clinical Psychologists, Indian Society of Professional Social Workers have been involved in various aspects of service delivery, training and awareness in this area. Members of such organizations are themselves directly involved in service delivery either through government or private hospitals, medical colleges or the voluntary sector.

#### **H. Training and Research in Mental Health**

The future development of mental health services in the country will be dependent on development of human resources and research into areas in the field of



mental health with specific relevance to the country. The training of doctors, nurses, and all categories of health personnel should include principles of basic mental health care. Facilities for professionals such as psychiatrists, psychiatric nurses, clinical psychologists, psychiatric social workers and personnel in psychosocial rehabilitation should be expanded and streamlined. National institutions such as NIMHANS and CIP, Ranchi should focus their research efforts on problems which have special reference to our population.

## **I. Legal Provisions and Legislation**

The Mental Health Act, which is currently followed, was passed by Parliament in 1987. It was only several years later that this Act was implemented. It is still not implemented in many States of the country. Mental health professionals have found various difficulties with the Act wherever it has been implemented. Similarly provisions for persons with mental disorders in the Persons with Disability Act of 1995 have several lacunae. Therefore there is a need to periodically review existing legislation and plan amendments or bring in new legislation from time to time.



# CHAPTER-12

## RECOMMENDATIONS

Most of the mental hospitals in India were established in the 19th century during the British rule. Given the fact that there was no effective treatment for mental illness at that time, the aim was to prevent the public from being harmed by the 'lunatic'. As a result most of the hospitals or asylums, as they were called, were built like prisons. The hospitals built for the British patients were better in terms of infrastructure and amenities than those built for the Indian patients.

The 1950s, however, saw a revolution in the treatment of mental illness; the introduction of Chlorpromazine, an anti-psychotic drug. Many of the symptoms, which the public feared and associated with 'madness', such as violent behavior, could now be controlled. Many patients improved sufficiently enough to be able to go home. However, the long years of living in an institution had a detrimental effect on the patient being cut-off from normal life resulted in loss of functional and social skills. This led to the development of a variety of behavioral, psychological and psychosocial treatments that could help reduce the disability. The emphasis shifted from merely 'managing the patient' to treating the patient and enabling him to remain in the family and community.

The advances made in the biological treatment of major mental illness have had far reaching consequences. Effective medical management has resulted in the symptoms of the illness being brought under control fairly rapidly. Many patients do not need to be hospitalized for long periods and often can be managed as outpatient. This, in turn, has led to the growth of general hospital psychiatric units. These units have played an important role in reducing the stigma attached to mental illness. The services are accessible, facilitate early recovery and allow the patient to lead as normal a life as possible. Today, the majority of persons suffering from mental illness are treated on an outpatient basis.

What then is the role of the mental hospital? Are they to be declared as obsolete and defunct? Have they outlived their purpose? The answers are neither easy nor absolute. Mental hospitals continue to play an important role as part of the spectrum of services that may be required in the course of treatment. There will always be a small proportion of patients who do not respond adequately to treatment in the initial period and require prolonged and specially targeted treatment initiatives. There are also patients who do not respond to treatment at all, have significant disability and are unable to function independently in the community who require long-term care.



Ideally, therefore, mental hospitals should be centers of specialized health care offering a variety of diagnostic and therapeutic services. They should have trained professionals from a variety of disciplines all working with a common goal of providing better quality of care for the mentally ill. These services should be accessible and affordable.

In reality, however, the mental hospitals are a far cry from what they ought to be. The findings of the project reveal that there are predominantly two types of hospitals. The first type does not deserve to be called 'hospitals' or mental health centers. They are 'dumping grounds' for families to abandon their mentally ill member, either due to economic reasons or a lack of understanding and awareness about mental illness. The living conditions in many of these settings are deplorable and they violate an individual's right to be treated humanely and live a life of dignity. Despite all the advances in treatment, the mentally ill in these hospitals are forced to live a life of incarceration.

The second type of 'hospitals' are those which provide basic living amenities. Their role is predominantly custodial and they provide adequate food and shelter. Medical treatment is used to keep patients manageable and very little effort is made to preserve or enhance their daily living skills. These hospitals are violating the rights of the mentally ill person to appropriate treatment and rehabilitation and a right to community and family life.

On the basis of the survey of all the 37 government mental hospitals and visits to a majority of these (33) a list of recommendations is presented. This list is exhaustive because it is intended to address the needs of both the types of hospitals mentioned above. Suggestions specific to a hospital have been made following the description of infrastructure and services available in that particular hospital in the state report (Vol.II)

This set of recommendations is intended to lay down the minimum requirements that need to be met in order to provide quality care in mental health facilities. Many of the suggestions are practical ones and can be implemented even within the existing framework. Some of the suggestions require additional financial resources. It will enable health planners and administrators to allocate their resources more judiciously. Finally, and most importantly, it will form a benchmark for hospitals to rate the adequacy of their own services.

The list of recommendations is presented under several headings that are arranged according to the structure and function of a mental hospital.

## **OUTPATIENT SERVICES**

1. Each hospital should run an outpatient service, preferably in a separate block,



which is easily accessible. The services should include the following:

Regular outpatient service every day between 9 am to 3 pm except on Sunday.

- a. There should be a reception counter and a general inquiry facility, which can be manned by volunteers.
- b. The waiting hall should have adequate seating arrangements. There should be at least 6 consultation rooms with facilities for individual physical examination and interviews by mental health professionals.
2. Basic amenities like toilets, drinking water and a canteen are essential.
3. There should be a registration counter with a nominal charge. Charges for services should be on the basis of income. All hospitals should provide free services for patients below a certain income level. Declaration of income can be verified by a medical social worker.
4. Adequate staff to run these services smoothly and efficiently should be provided. Services of clinical psychologists and psychiatric social workers should also be available in the outpatient.
5. The psychiatrist on duty has the powers of admission and discharge as per the Mental Health Act 1987 and this should be strictly implemented.
6. All forms of modern treatment should be available. These include:
  - a. Essential drugs, which should be given for a period of one month.
  - b. Psychoeducation and counseling at individual, family and group level
  - c. Psychotherapy and Behavior therapy.
  - d. Family and social therapies.
  - e. Only modified ECT is to be administered. The ECT unit should have the service of a qualified anesthetist and separate rooms for waiting, preparation, administration of ECT and recovery.
7. Laboratory facilities should be improved so that, in addition to routine blood and urine examination, serum lithium and screening for VDRL, Hepatitis B and HIV can be done. Other basic investigation facilities like X-ray, ECG and EEG should also be available.
8. A good medical record section is necessary to maintain confidentiality. It should have facilities for easy retrieval of files. A trained person should be in charge of the section.
9. Telephone facilities and an ambulance service are mandatory.



10. A separate dispensing counter for those availing free medications should be present.
11. A medical store to provide drugs at subsidized rates and which should be open 24 hours in every hospital.
12. There should be some provision for accommodation for a day or two for patients and family to use while availing of outpatient services. This is especially necessary in hospitals where many patients have to come from long distances.

### **Casualty and Emergency Services**

1. There should be a 24-hour casualty and emergency service, which attends to all psychiatric and medical emergencies. Patients can be admitted through the casualty after the outpatient service is closed. The emergency ward should have a minimum of 5 to 10 beds and should be well equipped with emergency medicines, intravenous fluids, oxygen cylinders, Boyles apparatus etc especially for handling cardio-pulmonary emergencies.
2. Separate staff should be assigned for the casualty and emergency service and the nurse to patient ratio should be 1:1. There should be a duty doctor's room, a nursing station and toilets and other basic amenities.

### **Short Stay Ward**

1. A short stay ward of 5 to 10 beds to admit emergency cases for observation and treatment should be provided. This ward should have 8 nurses, 6 ward attenders and 4 sweepers to work round the clock. A relative/attender of the patient should be permitted to stay with the patient. In these wards, patients should stay for 24 to 48 hours. They should be then either managed on an outpatient basis or admitted in the regular wards.

## **INPATIENT SERVICES**

Just like any other general hospital, a mental hospital should also have 'open' wards. Essentially this means that a relative can stay with the patient during his stay in the hospital. This reduces the number of nurses and attenders otherwise required as well as makes the family involved in the treatment process.

1. The open wards in the general category should not have more than 15 to 20 beds in each ward. They should be well ventilated with fresh air and light. There should be a separate cot, mattress and pillow for each patient and the distance between the two cots should be a minimum of 3 ft. There should not be any floor bed. Two sheets and a blanket should be provided and the bed



linen changed at least once a week. Individual lockers for personal belongings are to be provided. The family member should be able to stay with the patient. This could be in the form of a bed that can be rolled out from under the patient's cot. If possible they can be provided food or arrangements to cook their own food and canteen facility should be available. There should be adequate number of toilets and bathing and washing platforms for the relatives. Drinking water facility should be available in the ward. There can be a separate visitor's room where other family members and friends can come and talk to the patient.

2. Closed wards are to be limited to unmanageable cases and cases sent by the magistrates. There should not be any cells. All the existing cells are to be converted into small wards with all amenities. Majority (at least 90%) of the admissions should be on a voluntary basis in open wards and only 10% in the closed wards.
3. Each ward should have one toilet and one bathroom for 5 patients. There should be continuous water supply and basic amenities like buckets and mugs. Adequate privacy must be provided. Open air bathing and open toilets are to be avoided at all costs. Mirrors to facilitate dressing must be provided. Fans and heater facilities must be provided as per the weather conditions. Electrical lighting should be sufficient for reading purpose at night. Where electrical supply is erratic, provision for generator to provide minimal lighting can be made.
4. Patients should be encouraged to wear their own clothes. Hospital clothing should be culturally appropriate. Each patient should have 5 sets of dress, 2 towels, 1 blanket, 2 sweaters, a stainless steel plate and stainless steel tumbler, toiletries like tooth paste, tooth powder, hair oil etc. Female patients should be provided with adequate sanitary napkins during the menstrual period. Routine shaving of the head should not be done. Delousing and debugging must be done before the patient is admitted in the ward so as to prevent other patients from being infected. Facilities of a barber must be provided every week for the male patients and face shaving must be done with aseptic precautions.



5. There should be a nursing station for each ward with all the facilities for storing linen, drugs, IV sets. It is better to have a treatment room adjoining each ward. The nurses should record daily observations. Activities of each ward must be structured. These can include the practice of Yoga; physical exercises, indoor and outdoor games. Recreation facilities like radio, television and a daily newspaper in the regional language to be made available. Occupational therapy should also be provided.
6. Volunteers and trainees posted for block placement should be encouraged to spend time with patients and involve them in social and recreational activities.
7. The records of the patients must be maintained properly. There should be only one file for each patient, including the outpatient file and earlier admissions. The psychiatrist should see each patient at least twice a week.
8. Adequate deposit (3 times the fare) must be collected from the relatives of the patients, at the time of admission of the patient so that the patient can be discharged and sent home with a hospital staff in case relatives are not present.
9. There should be a separate inpatient facility for patients with criminal record. There should be proper police escort for the safe custody of patients with criminal records.
10. There should be a dining hall where the patients can eat with dignity. The food to the patients must be served hygienically and with care. Special provision must be made for patients who are unable to feed themselves.
11. There is a need to have a separate block for private wards with 15-20 beds for men and women separately with all the amenities, recreation facilities, nursing

### **Structured ward activities**

6 am to 7 am: waking up and attending to personal hygiene

7 am to 8 am: physical exercises

8 am to 9 am: breakfast and medication administration

9 am to 12.30pm: ward rounds, indoor games, reading, listening to the radio, reading newspaper or watching television/ occupational and rehabilitation therapy

12.30 to 1.30pm: lunch

1.30 to 3.00 pm: medication administration and post lunch rest

3.0 to 3.30 pm: coffee or tea

2.00 pm to 4.00 pm: indoor occupational therapy

4.00 pm to 7.00 pm: out door games and recreation

7.00 pm to 8.00 pm: watching television, bhajan and other group activity

8.00 pm to 9.00 pm: dinner



station, and a visitor's room. These facilities have to be provided in each hospital. Relatives may be permitted to stay with the patients. Private wards will attract people from the upper socio-economic strata and help reduce the stigma and improve the image of the hospital. The charges may be fixed as per the respective state government policies.

## **INTENSIVE CARE UNIT**

Every hospital should have an intensive care unit with separate nursing staff, ward attenders and sweepers. Each unit should have at least 10 beds, 5 for male and 5 for female with facilities like ECG, intubation and for intravenous infusion.

### **Duty Doctors**

There should be a duty doctor in the hospital duty room on call round the clock to attend to any emergency. The duty doctor's room should have the basic amenities of a toilet and drinking water.

The staff in the wards should be as follows

1. Nurse to patient ratio should be 1:3 in a teaching hospital and 1:5 in a non-teaching center. This is as per the recommendation of the Nursing Council of India.
2. Ward Attenders 1:10
3. Sweeper 1: 10
4. Barber 1 : 100

## **SUPPORTIVE SERVICES**

### **Kitchen and dietary services**

Dietary Section or Kitchen should be under the supervision of a dietician and have the following facilities:

1. Cooking should be done on gas in stainless steel vessels. The cooking platforms should be tiled for easy maintenance. There should be running water.
2. The gas cylinders should be stored in a separate room.
3. There should be adequate storage facilities, which are rat proof and free of cockroaches and other mites.
4. Cold storage for perishables such as vegetables and fruits must be provided.



5. Hospitals, which get daily supply of provisions and perishables on annual contract basis, should ensure that the quality is maintained.
6. The staff in the kitchen should be clean and wear a uniform, cap and apron. There should be a changing room, toilet and washing facility. They should undergo periodic medical checkups and be prescribed antihelmenthics when necessary.
7. The dietician and one other staff should check cooked food. There should be an office and record room.
8. The food should be transported in closed containers to the dining area.
9. There should be a separate dining hall for male and female patients.
10. Food should be served in ladles in steel plates and drinking water served in steel glasses.
11. The general atmosphere should be pleasant.
12. The timings for serving the food should be as follows:

Morning tea/coffee	:	7 am
Breakfast	:	8 am
Lunch	:	12.30 to 1pm
Tea/coffee	:	4 pm
Dinner	:	7 to 8 pm

Presently the serving of food is done according to the shift timings of the staff. This results in patients being served breakfast at 6 am and dinner by 5 or 6pm. This practice should be stopped and the shift timings modified to accommodate these changes.

13. A well balanced diet with at least 3000 calories for males and 2500 calories for females must be provided.
14. Provision for special diet for the physically ill or diabetic patients etc must be made.
15. Food waste must be disposed properly.
16. Kitchen should be connected by phone with the rest of the hospital.

## Laundry

Supply of clean and fresh linen is essential in a hospital. Care should be taken that the linen is washed properly. Many hospitals that have not paid sufficient attention to this have a large number of patients with skin infections and lice infestation. The laundry should have the following:



1. A laundry supervisor and one washerman for a unit of 50 beds.
2. There should be separate staff for distribution.
3. Laundry should be mechanized and have modern facilities such as washers, dryers and ironing.
4. There should be a separate area for receiving dirty linen.
5. Linen must be decontaminated in a separate area.
6. There must be a separate drying yard.
7. A separate room should be provided for storing the washed linen.
8. An area and staff for repairing and mending the linen should be identified.
9. Linen should be distributed in trolleys.
10. A committee consisting of MS/RMO, Chief Nursing Officer/Matron and the laundry supervisor must do condemnation of linen at least once in three months.
11. The laundry section should be connected by telephone to the rest of the hospital.

## **Medical Stores**

Medical stores should have the following:

1. Telephone facility, office room, record room and pharmacist's room.
2. Store room/main stock room to store at least 3 months requirements of the hospital drugs.
3. Refrigerators to store certain drugs to retain potency.
4. Issue counter where one week's quota of drugs is supplied for each ward. All hospital supplies other than drugs and linen are stocked here. This includes cleaning materials, toiletries for patients and equipment for the wards. At least 3 months stock should be available at any given point of time.

This store should be managed by a First Division Clerk and assisted by a junior staff.

## **Medical Records Section**

Each hospital should have a medical records section headed by an officer trained in handling of medical records. He should have adequate staff.

1. The department should have a telephone, office room and a large space to store the records of the patients. Each patient should have only one file for



continuity of records.

2. Storage should ensure that records are well preserved and maintained.
3. There should be proper retrieval system of the files.
4. All the stationery and printed forms required for the outpatient and inpatient are to be stored here. Stock of at least 3 months supply should be present. The stationery includes registration forms, admission forms in compliance with the Mental Health Act 1987, investigation forms, treatment sheets, follow-up sheets
5. There should be provision for indexing the patients by name wise and disease wise.
6. If possible file retrieval system should be computerized.

### **Waste disposal and management**

This is the most neglected area in any hospital service. . There should be proper facilities to dispose both hospital waste and food waste. Biodegradable waste must be converted to compost. Infected waste must be incinerated. Food waste could be used in poultry and piggery. Other biodegradable waste must be buried.

### **Central sterilization and supply department (C.S.S. D.)**

There should be a separate CSS D department managed by one supervisor, three nurses and six attenders. This should have a reception area, a sterilization area and an issuing section. The sterilization should consist of a) Decontamination, b) Washing, c) Assembly and d) Autoclave.

### **Liaison Services**

1. There must be regular visit of psychiatrists to jails and correctional institutions if specialist care is not available locally.
2. Liaison with general hospital services must be maintained.
3. Panel of specialists must be made available to the hospital. This should especially consist of an internist/physician, gynecologist, ophthalmologist, dermatologist and dentist.
4. Liaison with NGO's and other volunteer agencies which will facilitate discharge of patients, rehabilitation activities and placement of patients in jobs or other residential facilities must be made.

### **General Guidelines for the Hospital Administration**

1. There should be a good communication system i.e. intercom, telephone, fax and Email.



2. There should be a good telephone system within the campus connecting the wards, service departments, outpatient services, consultants' rooms and the administrative office within the campus.
3. There should be a good communication system from the campus to outside.
4. Good lighting using sodium vapor lamps must be provided in the whole campus,
5. There should be one or two generators to ensure continuity of power.
6. There should be overhead tank/tanks for regular water supply.
7. Computer systems can be introduced in the hospital.
8. There should be a Public Relation Officer to attend to the grievances of the public.
9. Good approach roads should connect wards, service departments, outpatients and central office.
10. Every hospital should have at least 2 ambulances, one for shifting the patients with in the hospital and one to send to other hospitals. Other ambulance use for community mental health services.

### **Hospital Administration**

1. The Medical Superintendent/Director shall have administrative/financial and legal powers to ensure proper functioning of the hospital. The Deputy Medical Superintendent and the RMO could assist him. Psychiatrists should hold these three posts. The Medical Superintendent should be assisted by a Lay Secretary at the level of Under Secretary to the Government of India who in turn will have enough staff to run the hospital.
2. The specific duties and areas of routine hospital functioning can be decentralized.
3. The number of beds can be divided among psychiatrists including medical superintendents to form functional units. The psychiatrist heading that unit can do admission, discharge and other routine clinical decisions. This will also ensure continuity of care and increase the personal contact with the patients belonging to that unit.
4. The MS must hold regular meetings (monthly) of the professional staff (Psychiatrists, Clinical Psychologists, Psychiatric Social Workers, and Psychiatric Nurses) to discuss matters pertaining to clinical services and ways of improving quality of care.
5. Hospital Management Committee consisting of Medical Superintendent/Deputy



Medical Superintendent/Administrator/Resident Medical Officer, Heads of Nursing and psychiatry, Heads of supportive services such as Diet, Laundry, Medical Records Section, Engineering Section must meet monthly to ensure smooth functioning of the hospital with respect to repairs, regular supplies of articles, drugs etc.

6. Hospital Management Committee or the Medical Superintendent should have the powers to receive donations from the public, voluntary organizations or other institutions in cash or kind without any limits. Such donations should be entered in a separate register maintained for this purpose. Tax exemption for cash donations can be provided.
7. The Drug Purchase Committee under the Chairmanship of the Medical Superintendent should form a list of drugs necessary for the coming year and submit to the Central Purchase Committee of the State. The Medical Superintendent should be a member of the State Drug Purchase Committee. However, the Medical Superintendent should have power to buy drugs worth Rs. 5000/- in emergency conditions.
8. The purchase of linen must be made from State- approved Co-operative Societies and the State should supply a list of names of such societies, so that prompt supply is ensured.
9. Dietary articles should be purchased from Government Agencies, Janata Bazaars, and regular Co-operative Societies or by calling for quotations.
10. The Medical Superintendent should have power upto Rs. 5000/- for local purchase.
11. The current procedure of the Group 'D' Staff coming under the control of overseer as practiced in some hospitals should be stopped immediately and all the group 'D' staff should come under the control of the Nursing Department.
12. The administration should be responsible for the day to-day cleanliness, maintenance of basic amenities and services such as water supply, electricity and sewerage systems, etc.
13. The administration should ensure the optimum utilization of all the medical and electronic equipment.
14. The administration must ensure the maintenance of an appropriate sterilization system and also an appropriate waste-disposal system.
15. The administration should ensure an appropriate system of inventory of medical stores, and an appropriate system of stock registers for the kitchen, linen and other supplies. A similar procedure for stores-purchase and stock-register maintenance should be followed.



16. Separate supply department should be set up to monitor the supply of essential items and drugs.
17. The administration is responsible for the maintenance of a green environment in the hospital premises. This should include planting of fruit and flowering trees, flower garden, lawn and other facilities. This could be given to a private agency on contract basis.
18. A private security agency could be employed to look after the security requirements of the hospital.
19. The Medical Superintendent of hospitals within each state must have a meeting with the health directorate/department at least once in 3 months (quarterly) and more frequently if required, to discuss administrative issues. The venue of the meeting may preferably be located in each of the hospitals in turn so that problems and progress in each can be discussed and shared. This will also reduce delays in paper work and correspondence.

## **Rehabilitation Services**

Rehabilitation forms an important component of the comprehensive mental health program. Persons with chronic mental illness develop disabilities in all spheres. Due to the advances in pharmacotherapy the patient's symptoms can be more easily controlled. Being symptom free is however, not necessarily total recovery. Efforts must be made to reduce the patients' disabilities and optimize their level of functioning. For this a well structured, rehabilitation center attached to each hospital is very much essential.

Rehabilitation is successful when a multidisciplinary team, comprising of a psychiatrist, clinical psychologist, psychiatric social worker and occupational therapist work together in a complementary manner.

Rehabilitation activities should be started in the individual wards. Structured activity of all the patients with emphasis on training in activities of daily living skills, including personal care and grooming must be ensured. This should be carried out under the guidance of the staff nurses. The family member attending on the patient should also be involved in this activity. Facilities for recreation and socialization must be provided in each ward. For example, indoor games, newspapers, television, radio, and group activities.

Apart from these ward activities there is a need for establishing a separate rehabilitation block in each hospital. Rehabilitation services could include carpentry, tailoring, candle making, paper cover making, basket making, mat weaving, bakery, printing, craft and needle work. Regionally marketable products utilizing the local available resources should determine the type of activity.



For these activities help from the State's Small Scale Industries Department could be taken. Several of the ward attenders who have knowledge of vocations like carpentry and tailoring could be sent for short-term training and be upgraded as assistant instructors.

Most of the mental hospitals have vast area of land available. Many of the patients and many of the group D' staff are from a rural background. Under these circumstances one can easily start agriculture, horticulture and dairy activities without much difficulty. Help from the agriculture and horticulture departments of the state governments could be taken. A separate supervisor deputed from the state could look after the activities.

## **DAY CARE CENTER**

Patients who are discharged from the hospital and are not engaged in household or occupational work can utilize the services of a day care center. A day care center should run from 9am to 5pm. It can be located within the hospital campus or in the community. It should be easily accessible and well connected by public transportation. Transportation could also be provided by the hospital.

1. A day care center provides a structured activity schedule, which includes recreational and occupational therapies. In addition, specialized inputs by the psychiatric nurse, clinical psychologist, occupational therapist and psychiatric social worker are to be made available.
2. The psychiatric nurse should ensure that patients are well groomed and have the necessary skills to look after their personal hygiene, take medication regularly and have the social skills for day to day interaction.
3. The clinical psychologist provides services such as a) psychological testing, especially of cognitive functions, to assess the level of cognitive deficits and help in the preparation of an appropriate work schedule, b) Cognitive-behavioral therapy to target specific problem behaviors or symptoms that have not responded adequately to treatment and c) Individual supportive therapy to enable the patient to cope with his illness, make realistic plans and function at an optimal level.
4. The occupational therapist should plan the nature of work the patient can be engaged in and monitor the work output in the section along with the instructor. Work skills can be rated and cash incentives provided for all the patients. When the patient reaches an optimal and stable level of functioning, the occupational therapist should inform the psychiatric social worker regarding the possibility of outside job placement.



5. The psychiatric social worker should be involved in working with the families and helping the patient and family to adjust. They also have to help patients return to their existing jobs or find a new occupation.
6. By attending a day care center, the patients develop a routine working habit, improve on existing skills or develop new skills. In addition, they learn to look after themselves and live in the family and community. A small category of patients may need to use the facilities of a day care on a long-term basis. Such patients may not be in a position to function independently in the community or find a job etc because of their level of disability being more but not severe enough to warrant hospitalization. In addition to the structured activity their medication can also be supervised at the center. The day care center not only enables the patient to spend his time in a useful and productive manner, but also provides a respite for the family. This enables the family members to carry on with their own work during the day and reduces the burden on them.

### **Satellite Centers**

Day care center should be started in different parts of the city so that they are closer to the patient in the community. It is essential to involve voluntary and non-governmental organizations (NGOs) in the process of rehabilitation. They can play an important role by marketing some of the items prepared in the day care center and finding job placement for improved patients.

### **General Amenities for the rehabilitation department**

One telephone

Toilet and drinking facility

Office room

Store room to store the raw material

Sales section.

Multi purpose hall for indoor games and decoration activities

Office Staff for the rehabilitation center

2 clerks one junior and one senior and one attender

### **Rehabilitation monitoring committee**

There is a need for an independent rehabilitation committee with the medical superintendent as the chairperson. Representatives from various public and private sector industries and companies, the banking and insurance sector, members from the State welfare and small-scale industries departments, prominent citizens and



philanthropists can serve as members of this board. Mental health professionals, NGOs working in the area of mental health as well as representation from the patient and family should also be present.

## **HUMAN RESOURCE DEVELOPMENT AND TRAINING**

### **1. Mental health professionals**

**a. Psychiatrists** -Currently it is estimated that there are only three thousands to four thousands psychiatrists in our country. Every year nearly 350 to 400 psychiatrists qualify from different post graduate training centers spread all over the country. Out of them at least 25 to 30 go abroad. For our country with a population of 96 crores, we require at least 10,000 psychiatrists, providing a ratio of 1 psychiatrist for every 25 beds. Hence there is an urgent need to start post-graduate courses like DPM and MD in many more centers and to increase the number of seats in the available centers. All the mental hospitals should become postgraduate centers.

### **b. Clinical psychologists and Psychiatric social workers.**

These mental health professionals form an integral part of the mental health team. Their services are essential for the psychosocial management of mentally ill persons. There is a need for one clinical psychologist and one psychiatric social worker for 25 patients in both mental hospital and general hospital psychiatric settings.

They should be class I officers and the designation and pay scale should be commensurate with the qualification. Till such a time as posts are created or existing vacancies filled up, provision should be made to avail of these specialized services on part-time/contract basis or as visiting consultants.

One mental hospital in each region or state can be identified as a training center and start postgraduate courses in these areas.

### **c. Psychiatric nurses**

NIMHANS is the only center offering diploma in psychiatric nursing. More centers need to be started. Nursing schools / Colleges situated in places where there is a mental hospital can start diploma and master's level courses in psychiatric nursing.



## SUGGESTED STAFF PATTERN DEPENDING ON THE NUMBER OF THE BEDS

Staff Pattern	20 beds	21-50 beds	51-100 beds
Psychiatrist	1	2	4
G.D.M.O	1	3	4
Clinical Psychologist	1	2	4
Psychiatric Social Worker	1	2	4
Staff nurses	7	18	20
Ward attenders	6	15	30
Sweepers	6	15	-

The manpower requirement has been worked out for the over all mental health care in the institution. This would involve services provision in out patient, inpatient, and other areas of service.

### d. Inservice Training Program

Inservice training programs should be conducted regularly and periodically for all categories including ward attenders, safaiwalas, instructors and other persons working in rehabilitation services. This will facilitate a change in attitude of the staff towards mentally ill persons and provide better health care. In addition, during the inservice training program human rights of the mentally ill should be highlighted. Subsequently adequate steps should be taken to ensure that these rights of the mentally ill are not violated.

Opportunities for continuing professional education should be provided to the professional staff. They should get necessary travel and other allowances to attend at least one workshop or conference per year.

## 2. Training for Other Professionals

For professionals who are closely associated with the functioning of the mental hospitals such as the judiciary, police and officials in charge of prisons, a series of workshops need to be conducted. These workshops need to be geared towards making them understand the nature of psychiatric illnesses and their management. More



importantly, they should be made aware of the existing laws pertaining to mental health, for e.g. the Mental Health Act 1987, the Persons with Disabilities Act 1995, the Narcotics and Psychotropics Substances Act of 1985.

The practice of referring under the Indian Lunacy Act 1912, which has already been repealed must be immediately discontinued. This process was initiated in Kerala for the judiciary by Justice VS Malimath and found to be very effective.

## **Estate Department**

There is a need for establishing a separate estate department for preservation of and maintenance of the estates, lands, properties and infrastructure of the hospital. The details of which are listed below:

- a. The administration of the hospital shall have an appropriate Estate Department or Estate Cell dealing primarily with the task of maintenance of documents/ records of estate, land and properties, both movable and immovable, of the hospitals. The department/cell shall also be responsible for the following:
- b. Maintenance of proper records and registers regarding the extent of land. Estate Department shall conduct a survey and assess the extent of the land and ensure that no encroachments on the property take place.
- c. The Estate Department should also be responsible for the preparation of Land Use Plans, or Master plans, if necessary in consultation with expert bodies such as the Hospital Construction Corporation of India and to ensure that no construction and development activity inconsistent with such a master plan is embarked upon.
- d. Proper utilization of the extensive, unused land in many of the hospitals should be planned for, if necessary in consultation with the Horticulture Department of the State Government or other expert bodies, to develop an orchard, or to put the unutilized land to such gainful use without creating any third party rights or interests.
- e. The estate department should also be responsible for periodic inspections to ensure that the hospital buildings meet the basic standards for the protection of the Health and Safety of the patients and staff.
- f. It should also ensure that the space is sufficient for the number of patients admitted, and that reasonable space for specific treatment procedures, recreational activities, and receiving of visitors in terms of privacy, seating etc. is provided.
- g. It should ensure reasonable privacy for relevant bodily functions of the patients, with emergency safety procedures. The department should also ensure



the provision of adequate provisions for patients to secure their personal effects and belongings.

- h. It should ensure adequate lighting in wards, and for the security of the campus.
- i. The department should ensure that toilets are in good serviceable condition with a constant supply of water and set-up and maintain adequate sewerage and waste disposal systems.
- j. The Estate Department should also be responsible for the maintenance of the building structures, plants and machinery and keep them in a serviceable condition.
- k. The Estate Department, in so far as the requirements of Civil and Electrical Engineering services are concerned, may secure appropriate personnel on deputation from the Government, or local authority.
- l. Periodic reports from the Estate department about its functioning should necessarily be placed before the Hospital Committee for consideration and review.
- m. Estate Department should be headed by Executive Engineer/Assistant Engineer deputed from the State Department and should work under the control of the Medical Superintendent.
- n. One unit of the Estate Department comprising of Junior Engineer, Electrician, Plumber, Mason, should have residential accommodation in the campus. This will ensure that routine work/repairs take place without delay.

### **Utilization of vacant land**

All the mental hospitals have a large area of land often without a boundary wall. With the result, encroachment of land has taken place in many hospitals. Action must be taken to by the estate department to regain the lost land. The vacant land could be utilized for:

1. Agricultural and horticultural purposes utilizing the manpower available. This can also be taken up as part of the rehabilitation program especially for patients hailing from a rural background .
2. Housing the staff quarters. Many of the staff stay outside the campus and pay heavy rents. Provision of staff quarters will enable them to attend to their duty at the scheduled time as well as facilitate patient care.
3. Building new wards like open and family wards with modern amenities.
4. A new block for rehabilitation services and outdoor games.
5. Housing a new laundry block.



6. Building a Dharmashala Complex for poor patients with the help of donations from public and corporate bodies.

## Financial aspects

One of the salient findings of the project was the disparity in the cost per patient across different hospitals. This needs to be immediately rectified. Hospitals, which spent at least a minimum sum of Rs. 200 per person per day, were able to provide reasonable basic amenities. All hospitals can adopt this as a minimum guideline in their budget provision.

To provide mental health care in all the three dimensions viz., preventive, promotive and curative lot of financial resources are required to initiate the process. The Government of India has approved the National Mental Health Program of 1982, but because of a lack of funds and a lack of commitment from the Government of India and State Government, it has not been possible to implement the program though islands of activity have been initiated. Several National Workshops have been held and each time recommendations have been made but no action has been taken, due to a paucity of funds.

In this regard the State Governments have held the position that unless the Government of India funds 100% of the program, they would not be able to take up the National Mental Health Program or implement the Mental Health Act of 1987. Health being a concurrent subject unless both Government of India and State Governments come to some understanding, no further action is likely to occur. In advanced Western countries health receives nearly 18% of the budget. In contrast, in India only 3% of the budget is allocated for health. In an already low budget, the allocation to mental health is even lower.

In this regard the following suggestions are made:

1. The Government of India should provide 100% of the funds for the first 5 years. For the next 5 years, the State may contribute 50% of the expenditure and the rest by the Government of India. Subsequently the State Government can take over the entire program.
2. International Agencies like World Bank could be approached. Some years ago efforts were made to obtain World Bank funding, but not pursued vigorously.
3. International Funding Agencies like WHO, ILO, Ford Foundation, Rockefeller Foundation and other similar agencies could be approached.
4. The approximate projected cost of such an endeavor would be Rs. 1500 crores.



## **Welfare measures**

People working in mental hospitals are exposed to additional pressures such as working with the chronically mentally ill, long working hours and poor work conditions. Moreover, many of the staff are posted to the mental hospital as a 'punishment transfer'. Such staff disrupt the work ethos. This practice should be immediately stopped.

In order to prevent amotivation and burnout among the staff certain incentives/extra allowances should be provided at all levels. The quarters have to be provided at least for 50% of the staff and for all emergency duty staff including medical officers. Special allowances have to be considered by each state government. Recreation facilities for the staff and their families, including children should be provided.

## **Rights of the mentally ill**

The United Nations through its Declaration on Human Rights in 1948 and again in 1975 (Rights of the Disabled) has affirmed the basic principles of human rights of the mentally ill. The Constitution of India has recognized that the mentally ill are an under privileged section of society and have a right to equal status. The rights of mentally ill have emerged as a growing concern all over the world. In the Mental Health Act (1987) Chapter – 8, Section 81, a few provisions are enunciated.

All the categories of staff in the hospital from the medical superintendent to ward attenders should be made aware of these rights through a series of orientation programs. That these rights are protected should be ensured by the hospital administration. If any violation of the rights of the mentally ill should occur, the monitoring team within the hospital should take appropriate action against the individual in addition to preventive steps.

### **Rights of the mentally ill**

1. The right to be treated humanely and with respect for the inherent dignity of the person.
2. Right to personal liberty
3. Right to bodily integrity and appearance
4. Right to privacy
5. Right to appropriate treatment and rehabilitation
6. Right to be protected from cruelty and involuntary servitude
7. Right to be respected
8. Right to protection against exploitation or discrimination and a right to protection against abuse or degrading treatment
9. Right to community and family life once improved rather than a life of incarceration.
10. Right to refuse treatment



## Monitoring Mechanisms

1. Internal - The Hospital Committee, Board of Visitors, Board of Management could function as Internal Monitors.
2. External - There could be a Human right Cell for each Mental Hospital or at least one at State level consisting of Chairman, Human Rights Commission of the State. The Medical Superintendent of the Hospital, Directorate of Health Services/Medical Education. The Secretary, Health, or his nominee from the State. A senior Psychiatrist outside the hospital and a well recognized Social Worker.
3. The Central Health Authority dealing with implementing the Mental Health Act and a National Mental Health Program has to be strengthen and given the power of monitoring the Mental Health activities of the country including mental hospitals.
4. State Mental Health Authority established under the Mental Health Act has to be strengthened to monitor the State Mental Health Authorities.  
(Please refer Mental Health Act 1987 and Government of India Rules of 1990)
5. There should be a separate cell at the Government of India, Ministry of Health and Family Welfare with Joint Secretary as the Head. This Joint Secretary will exclusively deal with the subject of mental health.
6. There should be a separate cell at the Directorate General of Health Services level with Additional Secretary as the Head exclusively dealing with Mental Health. He could preferably a psychiatrist.
7. Currently Ministry of Social Justice and Empowerment (earlier Ministry of Social Welfare) is dealing with rehabilitation aspects of chronically mentally ill under persons with Disabilities Act of 1995. Unfortunately there is no coordination between this Ministry and the Health Ministry. There should be a mechanism of continuous intensive cooperation. Hence it is suggested a member from Social Justice and Empowerment ministry could be a member of the State Mental Health Authority and similarly a member from Health Ministry could be Member of the Central Coordination Committee formed under persons with Disabilities Act 1995.
8. Similar arrangements could be made at all the State level also



## CHAPTER-13

### SUGGESTED READING

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# PART-II







# CHAPTER-14

## INTRODUCTION TO PART- II

The National Human Rights Commission Project Report on Quality Assurance in Mental Health is presented in two parts. Part I contains a historical background of the establishment of mental health services in general and mental hospitals in particular. A comparison is provided between the various Government psychiatric hospitals. The standards of care in private psychiatric institutions and in general hospitals are discussed. The need for a comprehensive network of mental health care services is highlighted. Specific Recommendations to improve standards of care in mental health are made.

Part II presents detailed reports on each of the hospitals in the country. These descriptions are detailed in the following manner:

The reports begin with an introduction to each of the States in which the mental hospitals are present, in terms of geographical location, population, other demographic details and mental health services in that State. These details have been excerpted from the Manorama Year book 1996. This is followed by a description of each government mental hospital. The history of development of the institution, hospital infrastructure and the staffing pattern are described. The admission and discharge procedures and financial outlay follow this. The next section outlines the casualty and emergency services, outpatient and inpatient services, dietary and pantry facilities, supportive services, investigation and treatment facilities, medical records and rehabilitation services. The ensuing section deals with community services. Various court representations, legal issues along with the Board of Visitors and the Rights of the mentally ill are detailed in the subsequent section.

At the end of each report, a summary is provided. This highlights the important aspects of the individual hospital and makes specific suggestions for improvement. A set of suggestions for improving the mental health services in each State is also provided. These suggestions may be taken up by each State for immediate implementation.



\*\*Map not to scale

# INDIA

● MENTAL HOSPITALS





# CHAPTER-15

## ANDHRA PRADESH

### INTRODUCTION

Andhra Pradesh is the eighth biggest State in India, both in area and population. It covers an area 275,068 km and has a population of about 67 million (65,08,008). It is divided into 23 districts, with the capital at Hyderabad . It has 3 distinct regions: 1) the coastal region called Andhra, 2) the Interior region known as Rayalaseema and 3) the Telangana region. There are 2 mental hospitals in Andhra Pradesh, one located in the Andhra region and the other in the Telangana region. The third region, Rayalaseema does not have a mental health facility in the governmental sector resulting in-patients having to travel long distances. There is a great need to establish a mental health centre in this region.

Andhra Pradesh has 10 Medical Colleges and each medical college has 10 to 20 psychiatric beds. The staffing pattern is one Professor and one Additional Professor of psychiatry in each department. There are no posts of clinical psychologists, psychiatric social worker and psychiatric nurses. These medical colleges are at Vishakapatnam, Guntur, Tirupathi, Warangal, Kakinada and Hyderabad. Out of the 23 districts, 15 have psychiatric units with outpatient facilities only. Each of these 15 district hospitals has one psychiatrist. However, the state as a whole has about 100 psychiatrists in the government and private sector.

### INSTITUTE OF MENTAL HEALTH, HYDERABAD

#### Background

The present Institute of Mental Health (earlier known as Government Hospital for Mental Health Care) at Hyderabad was established in the year 1907 and originally situated at Jalna, which was part of the Nizam's Government and presently in the State of Maharashtra. After the change in the state policy this hospital was shifted to Hyderabad, the capital of the Nizam's state in 1908. The land was initially leased from the Royal Airforce at RS. 200 per acre, but subsequently handed over to the Nizam's government. The Nizam's government lost the empire during the police action in the year 1947-48 and the hospital land and buildings were handed over to the government of Andhra Pradesh. The landowners are now demanding higher lease amount from the government and have filed a case in the court. The medical superintendent has to attend the court and this takes away a lot of his professional time. The land has still not been handed over to the hospital authorities. Few barracks have been converted as staff quarters and a few as wards for the patients. Even



now there is a hangar for parking a small aircraft in the campus.

The total land area of the Institute is 48 acres, of which 2.4 acres have been taken over by the municipal corporation of Hyderabad and 1.5 acres has been taken over by Hyderabad Urban Development Authority (HUDA) for developing a nursery. The public works department (PWD) which was maintaining the land and buildings has handed over the land portion to HUDA in the year 1980 for developing the area. The HUDA has developed a nice garden in the hospital premises and also in the female ward. Some land has been handed over to the forest department for developing the area and also to help the hospital authorities maintain the greenery. This hospital has a total of 600 beds, of which 350 for male, 150 for female and 50 for patients with a criminal record. The OPD service was started in the year 1959. A family ward, which is more like an open ward, was started in the year 1983 by converting one of the barracks. An occupational therapy unit has been functioning from the beginning. The hospital was renamed as the Institute of Mental Health when it started the diploma course in psychiatric medicine (DPM).

The hospital is located within the city municipal limit and on the main road. It is easily accessible. There is a public road in the middle of the campus.

### **Infrastructure**

Unlike many other mental hospitals, the architecture of the hospital is not that of a jail. The floor space is not sufficient to accommodate all the patients. 'Pucca' buildings do not exist for all the wards. A new dining hall has been constructed and is ready for occupation.

All the patients are provided with cots and mattresses. The cots need to be painted. Pillows are not provided. Lighting, ventilation and fans are adequate in the wards. Corporation water supply is adequate during particular hours. Since there are no water tanks there is no continuous supply of water. Patients are provided hot water through the old method of boiler system. The toilet facilities are inadequate and several toilets have no taps. Hence the toilets are not kept clean.

Patients are provided with striped Jubba and pajama (for both male and females). Saris are not given to the female patients because of the fear of suicide.

The male patients are housed in large wards with 50 in each. The space between the cots is not adequate. As a result of this overcrowding, it is often difficult to control the patients. The hospital does not have individual cells.

### **Staffing pattern**

The medical superintendent is the overall in-charge of the hospital. An RMO on the clinical side and a gazetted officer on the general administrative side assist



him. There are 12 qualified psychiatrists and 2 posts are vacant. In addition, the post graduate trainees in psychiatry also help in the clinical services. Out of two posts of clinical psychologists, one is vacant and out of four social workers posts, three are vacant. There are 179 nurses. There is no psychiatric trained nurse. Motivated and committed nurses in service can be deputed for training in psychiatric nursing to Institutes such as NIMHANS, Bangalore. Currently, 48 posts of nurses, 91 posts of ward attenders, 1 post of occupational therapist and one post of X-ray technician are vacant. The state government has a ban on creating new posts as well as on filling up the vacancies. There is however a need to increase the number of professional trained staff.

## **Admission and discharge**

The Indian Lunacy Act, 1912 or the Mental Health Act, 1987 govern all admissions. This is because many of the judicial officers themselves are not aware of the new Act. Majority (97%) of the patients are admitted as voluntary boarders. There have been no suicides, homicides or escapes in the past five years. Out of 600 only 73 are long stay patients (more than 5 years). The average duration of stay in hospital is less than 2 months (51 days). About one third of the patients get readmitted. The common causes for repeated admission are poor compliance with medication and non-availability of medicine in the villages.

## **Finance**

There has been an increase of plan and non-plan budget over the last five years, but the increase is not significant. Current plan budget is 1.74 lakhs and non-plan is 193 lakhs. Salaries of the staff take away the bulk of the budget (76%).

## **SERVICES**

### **Casualty and emergency service**

These are available and roughly 20 patients per week utilize these services. Ambulance facilities are available. There is no short stay ward.

### **Outpatient service**

The hospital has outpatient (OP) facilities, and on an average, 250 to 300 old patients and 22 to 30 new cases avail of this service. In the OP, direct ECT is administered, as the service of an anesthetist is not available. On an average, 25 to 30 patients get direct ECT per day. Medical record section needs to be renovated and staff in the medical record section have to improve their knowledge and skills in the management of medical case records.



## **Inpatient service**

The wards are cleaned every day and the linen changed twice a week. The present laundry facilities are very poor, with only one washer man to wash the hospital linen and this is done using the old method of bleaching and boiling. This needs to be replaced by a modern washing system.

Cots with adequate bedding are provided but pillows are not given. This is because some time ago, one patient suffocated another patient (using a pillow). Except in the paying wards, patients are not allowed to wear personal clothing. No saris are supplied to the female patients because some years back a patient had committed suicide by using the sari. Head shaving is not mandatory.

The toilet facilities are inadequate and either there are no taps in the toilets or they are not working. This needs immediate repair/ replacement to ensure free flow of water supply in the toilets. There is no water tank in each ward building. With the result running water is a problem and there is no geyser to provide hot water in the wards. Hot water is provided to the patients through the old method of boiler system, which needs immediate attention. The Institute has given some land to the water supply board to construct an overhead tank to store water for regular and uninterrupted water supply to the entire campus.

There is a laboratory in the administrative block, which has the facilities to carry out routine blood and urine examination as well serum lithium estimation, VDRL, screening for Hepatitis B and HIV. There is a radiology department with an X-ray unit, which is functioning well. There is a new EEG machine, but no technician has been appointed and hence it is not in use. Psychological testing is not done.

Currently the kitchen is in an old building but cooking is satisfactory. However the new kitchen block with modern facilities is ready for use. The timings of service of food are reasonably good and 2,500 calories per patient at Rs. 14/- per day is provided.

Management of patients is by medication and ECTs. Violent patients may also be secluded. No psychosocial or behavioral intervention is provided. Minimal recreational facilities are present in the form of music, television and indoor and outdoor games. This institute has the necessary infrastructure for rehabilitation, but presently because of the government policy on recruitment, there is no occupational therapy staff and hence no therapy is carried out.

## **SUGGESTIONS**

- All the vacant posts should be filled up at the earliest.
- As many of the nurses should be sent for specialized training in psychiatric



nursing, such as the diploma or Master's level course.

- Rehabilitation services have to be improved
- Each patient should have a cot, mattress, pillow and bed sheet.
- Over head tank should be constructed for uninterrupted water supply to the entire hospital campus.
- A new building for starting a short stay ward, open wards and family wards to be built.
- Ambulance services should be made available.
- Hot water facility for bathing should be available in the wards.
- Number of toilets to be increased and maintained properly.
- Dress for the female patients must be modified (locally appropriate clothing such as sari or skirt/blouse).
- Medical record section needs improvement / modifications. Trained medical records officer should be incharge of this section.
- Only modified ECT should be given for both outpatients and inpatients.
- Medical superintendent to be given more financial and administrative powers.
- Medical superintendent should have the power to accept donations, in cash and kind to improve the hospital.

## **GOVERNMENT HOSPITAL FOR MENTAL CARE, VISHAKAPATNAM**

### **Background**

The Government Hospital for Mental Care, Vishakapatnam was started as a lunatic asylum during British India in 1863 with 94 patients. Prior to 1863, the mental patients were housed in the District Jail. Later they were housed in this campus in a rented building. The present hospital was built in 1871 to accommodate only 94 patients and it has developed in a phased manner to accommodate 300 patients at present. The Government in 1971 changed the old name "Mental Hospital" to "Government Hospital for Mental Care". Two decades ago, various wards were named by the then Medical superintendent as "Vishwamitra", "Vasista", "Srikrishna" etc for the male wards and the female enclosure as "Arundathi" with the wards inside being "Mythreyi" and "Vasavi".



A separate de-addiction ward was started in 1994 after prohibition of alcohol was introduced in Andhra Pradesh. A family ward with facility for relatives to stay along with patients and emergency psychiatric services were started in 1995 in a separate building specially constructed for this purpose. This is a teaching hospital attached to the Andhra Medical College and is involved in under-graduate psychiatric teaching from a long time. Post Graduate Diploma in Psychiatric Medicine (DPM) course was started in 1978 and a degree course i.e., MD in Psychiatry was started in 1984 with 1 seat for each academic year. The institution also caters to the teaching needs of various other related branches like Nursing, Social work and Psychology students who come from various academic institutions for exposure in the area of mental health.

### **Infrastructure**

The hospital has a bed strength of 300, 225 for male, 75 for female. Currently children are also admitted with the adults. The hospital is located in a vast area of 50 acres of government land enclosed by a strong compound wall. It has a jail like appearance. The old wards, about 30 in number, resemble jail cells with iron gates. Nearly one third of the patients are housed here and there is over crowding in the cells. Except for the new dining hall, all the other wards have tiled roofs. Except two wards where families are allowed to stay, all the other wards are closed wards. There is a separate ward for patient with criminal records and a separate ward for chronic patients.

Water supply, electricity, toilet, telephone facilities are very poor. The quarters of the Resident Medical Officer and Medical Superintendent are in need of major repairs. There is an open drainage system throughout. The service roads inside the campus are poorly maintained and need immediate attention.

### **Staffing pattern**

The medical superintendent is in-charge of the hospital and there are 4 qualified psychiatrists to assist him. There are 11 general duty medical officers. The posts of clinical psychologist and psychiatric social worker are vacant. Out of 56 posts of nurses, 45 are occupied and 11 post are vacant. There are 62 posts of ward attenders out of which only 32 are working. Many other posts of various other categories are vacant. There is a need to fill up existing vacancies and create new posts of clinical psychologist, psychiatric social worker and psychiatric nurses.

### **Admission and discharge**

Majority (95%) of the admissions are voluntary and 5% through the courts (regular as well as under trial convicts). The admissions are made as per the repealed Indian Lunacy Act of 1912 and Mental Health Act of 1987. This suggests



that there is a need to orient the legal profession regarding the new developments. In spite of raised walls, escape rates continue to be high; for example during the year 1995, 116 patients escaped. Death per year has been reduced from 17 in 1992 to only one in 1996.

## **Finance**

There is no division of budget as plan and non-plan, and only non-plan budget is provided. Though there is a progressive increase in the non-plan budget it is not sufficient to meet the demands. Nearly 75% is for the staff and budget for food, drugs, linen and maintenance is poor. Donations have been received in kind mainly electrical fittings in the form of fans and lights.

## **SERVICES**

### **Casualty and emergency service**

Casualty and emergency services are available and fairly accessible. Around 11 to 12 patients in a week utilize this service. Majority (80%) of these patients get admitted, about 15% continue treatment on outpatient basis and 5 % of them are referred to other hospitals. There is no telephone facility available. The toilets are poorly maintained with inadequate water supply.

### **Outpatient service**

The medical superintendent's old quarters has been converted as an outpatient block. The whole block is in poor condition and does not have basic amenities. Free drugs are given only for one week as per the government policy. The facilities for the patients waiting to see the doctor are very poor. On an average, 10 to 12 new cases, and 40 to 50 old cases visit the hospital for follow up. In the outpatient, direct ECT services are provided for three days in a week, and about 25 ECT's are administered each day.

### **Inpatient service**

The over all condition of the wards is grossly inadequate. The wards are not cleaned regularly, have a dirty smell and are full of cobwebs. The few bed sheets that are in use are not clean and most patients do not have any sheets and blankets either to cover the bed or themselves. Due to the overcrowding many patients sleep on the floor. The wards are full of mosquitoes.

The whole campus is without light in the night and both the female and male wards are poorly lit. The institute gets corporation water supply. There is no other source of water to the hospital either by bore wells or water tanks. There is no



storage facility and this results in there not being a continuous water supply. The entire hospital (OP, wards, kitchen, toilets, etc) needs a more reliable supply of water to keep the premises clean. There is one washer man for the entire hospital, who is unable to cope with the load. There is a need for a modern laundry facility.

About 1/3 of inpatients are locked – up in cells and each cell has at least 3 to 4 patients. There is no toilet and provision for urination is made through an opening made in the wall in one corner of the cell. A few cells are provided with cots, which are not in proper condition. Patients are often left in these cells with their hands and feet tied, without proper clothing etc. At times patients have sustained injury by repeatedly banging the head against the iron frame of the cell.

Food is of very poor quality. Though there is a dietician employed by the Institute, the cooking has been given to a private contractor. The diet for each patient is said to comprise of 2500 calories at Rs. 14/- per head. The kitchen is in a bad shape and needs renovation. The food is prepared by gas, but the vessels need to be replaced. Currently the food is served in an open space and for the patients in the cells the food plates are pushed through the bars.

The family ward does not have any family intervention services. It is more like an open ward with 12 beds, where the relative can stay with the patient. The family members are not given any food, but permitted to share the food and bed of the patients.

Basic laboratory investigations such as routine blood and urine examination and serum lithium estimation are done. Psychological testing is not carried out. Treatment is only medical with medication and direct ECTs being administered. No psychosocial or behavioral interventions are carried out due to lack of professional staff.

There are no recreational facilities. Patients are not allowed to go out either for exercise or to play games because the administration is afraid of patients escaping. There is no occupational therapy section and no efforts made to rehabilitate the patients.

## SUGGESTIONS

- Better amenities are needed in the outpatient in the form of a large waiting hall with adequate seating, fans and lights, toilets and drinking water.
- The cell wards should be immediately abolished. All dilapidated wards to be demolished. New wards to be constructed that can accommodate the patients comfortably (Not more than 20 in a ward).



- Each ward should have 6 tube lights, 8 fans, 4 toilets, 2 bathrooms and a nursing station.
- Each patient should be provided with a cot, mattress, pillow and bed sheet and adequate change of clothes.
- Drinking water in closed containers with a tap and adequate number of tumblers should be provided in each ward. Potable drinking water in the containers should be replaced every day.
- An overhead tank should be constructed so that running water is available in the toilets and all the wards, laboratory etc.
- All the toilets should have half doors for privacy in the male and female wards.
- Mechanized laundry should be installed in the hospital to ensure the supply of clean, neat, and tidy clothing and hospital linen.
- Good quality (nutritive) food with 3,000 (three thousand) calories should be supplied to each patient with dignity and respect. Food should be cooked in steam and supplied in closed containers to the wards. Food should be distributed to the patient either in a dining hall or in the verandah. Each patient should be given a steel plate, a tumbler and a cup. This should be sterilized and stored in a specified place.
- All the vacant post especially of mental health professionals should be filled up immediately. Clinical psychologists, psychiatric social workers and psychiatric nurses are urgently needed to provide psychosocial inputs at the individual and family level.
- Daily ward-based activity for the patients should be drawn and staff to ensure that it is carried out.
- Occupational therapy is not available hence they should be established in a separate block. This should include horticultural activities, as there is a lot of unutilized space.
- Facilities for day care centre should be provided.
- A separate medical record section is recommended for better retrieval and storage of records. Trained personnel should handle this. Administration should be computerized for greater efficiency.
- Radiological services for the patients should be provided by installing an X-ray plant.
- All the roads connecting the wards and other facilities should be repaired immediately. Adequate street lighting on the campus.



- Communication facilities should be provided connecting all the wards, outpatient, administrative building, laboratory, duty doctor's room and nursing stations.

### **Summary and suggestions for the State**

The State of Andhra Pradesh has not paid adequate attention to the quality of mental health care being provided in the two hospitals in the State. Although the condition of the hospital at Hyderabad is marginally better than that of the hospital in Vishakapatnam, the condition overall is far less than desirable. Provision has to be urgently made in the plan budgets of both the hospitals to improve the infrastructure. However, if the quality of care has to change from being custodial to therapeutic, it is imperative that there are adequate numbers of mental health professionals.

In order to achieve this certain administrative policy decisions may have to be relaxed. The State of Andhra Pradesh has a general ban on recruitment. In addition, it has a policy wherein posts that are vacant have to be filled up by candidates belonging to the same geographical region. This is particularly applicable in the Telengana region and has seriously affected the hospital in Hyderabad. These two policies may have to be reconsidered in the case of these two hospitals, as they do not have even the minimal staff required. The absence of appropriate treatment amounts to a basic human rights violation.

In addition, to the existing difficulties there is a lack of sensitivity on the part of the administrators. For. E.g., Six posts of occupational therapists in the Hyderabad hospital have been filled up by persons who were reassigned from a project. These persons have neither the qualification nor the experience to be in these posts. Such decisions not only hamper the functioning of the superintendent, but also disrupt the work ethos of other staff. The suggestions for the State are as follows:

- The State Mental Health Authority should develop a master plan to improve the mental health care facilities in these 2 hospitals (Hyderabad and Vishakapatnam) with help of an expert committee. There is a need to improve the basic living conditions in the hospitals, more so in Vishakapatnam with respect to water supply, toilet facility, laundry services etc.
- The medical superintendent has should be given more administrative and financial powers.
- There is an urgent need to fill up existing posts of mental health professionals and, if needed create new ones. In addition to psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses are required to provide comprehensive and quality care.



- The Rayalaseema region of Andhra Pradesh has no psychiatric facility to provide mental health care either in the private sector or in the government sector. There is a need for a small hospital in this area.
- A few children are being admitted in the Vishakapatnam hospital and this is in violation of their rights. Children should have a separate facility.
- Psychiatric departments of all the medical colleges need to be strengthened in terms of bed strength, manpower, and community services.
- Frequent meetings of the medical superintendents of Vishakapatnam and Hyderabad with the Director of Health Services and Secretary Health should take place to discuss issues of common interest will ensure smooth functioning.





# CHAPTER-16

## ASSAM

### INTRODUCTION

The State of Assam has an area of 78,438sq km and a population of 22,294,562 with 11,579,693 males and 10,714,869 females. The density of population is 284 persons/sq km. The capital is Dispur (Guwahati) and there are 23 districts in this state. The literacy is 53.4% and per capita income is Rs. 3179/-. The state with this population and size has only one mental hospital in Tezpur with bed strength of about 500 patients. The medical colleges also have psychiatry units. The Guwahati Medical Colleges has 50 beds. There are no known private mental hospitals.

### THE LGB INSTITUTE OF MENTAL HEALTH, TEZPUR

The Lokopriya Gopinath Bordoloi Institute of Mental Health at Tezpur is the only mental hospital in the state of Assam. In fact, in the whole of the NorthEast region there are only 2 mental hospitals including this one. The other hospital is in Kohima. There are moves to build more hospitals in the North East region due to the lack of beds in the other states. The LGB Institute of Mental Health is situated in Tezpur, District of Sonitpur, about five hours by road from Guwahati.

### Background

This hospital was initially located in Dhaka. After reorganization of the Assam provinces in 1874 the hospital started functioning in 1876 with 21 patients transferred from Dhaka. Thereafter about 43 new patients were admitted. The original structures were destroyed by fire in 1898 and in its place a new structure was built by Ms. Zardine and Menizes Co. in 1926. The buildings were completed in 1932 and accommodated patients from the North Eastern states, North Bengal, Bhutan and Nepal. After being initially governed by the British and later the Govt. of Assam, the current governing authority is the North Eastern Council (NEC) as authorized by the Supreme court ruling and the Directorate of Health Services.

### Hospital Infrastructure

The Institute is a separate hospital (old and new) on either side of the road located on a sprawling campus. Currently the outpatient block, and two newly built blocks of wards housing male and female patients are located on one side of the road. The original mental hospital buildings are located on the opposite side of the road. Most of these buildings are in disrepair and about 100 chronic long stay



patients and criminal mentally ill are housed in serviceable buildings. Some of the support services like kitchen, laundry, administrative offices, laboratory and stores are located on the same side in the old buildings. A unique and interesting feature is a herd of deer that roam freely in the sprawling campus of the old mental hospital. Apparently one of the earlier medical superintendents had brought a pair of deer to the campus and they have multiplied over the years to a herd of over 100 of this protected species. The deer are looked after well by the staff and patients, with the help of veterinary physicians who are called in for help in case of disease.

The wards are comprised of dormitory type accommodation in the general category and single or double rooms in the paying category. There are adequate number of toilets, fans and each patients has a bed, linen, uniforms and others personal amenities. The number of patients has been reduced in the last 5-7 years from an unwieldy 1200 odd down to manageable 300 odd patients. In addition there are about 100 chronic long stay patients. The new buildings are in fairly good shape but the old quarters are in state of disrepair and unlivable. This is apparently due to poor funds and maintenance from the PWD department. A new facility (old jail premises) is the deaddiction facility that is awaiting commencement of service.

### **Staffing pattern**

The hospital is governed administratively by the North Eastern Council (NEC) and the Government of Assam. The medical superintendent (a psychiatrist and presently Joint Director of Health services) is the head. Under him are 5 qualified psychiatrists, 12 general medical officers, 1 clinical psychologist, 1 psychiatric social worker, 19 general nurses, 1 occupational therapist, 142 ward attenders and about 40 other support staff. There are about 6 office staff for the administrative offices. Almost 50% of all staff members stay in the campus in staff quarters. The working hours is 8 hours/days. There are no non-psychiatric visiting consultants and the staff are paid on the State Government pay scale.

### **Admission and discharge**

The procedure of admission is governed by the Mental Health Act, 1987 and admitting authority is the psychiatrist or the judiciary. Most of the admissions are voluntary by self or by relatives amounting to about 1800 per year. Reception order cases by a court order is less the 100 cases per year. Decertification is done by the hospital authorities and patients sent home with relatives or an escort or by self. The number of discharges equals the number of admissions. In a year, there are about 10-20 deaths, 1-2 suicides, 10-20 escapes and no homicides. The number of long stay patients are negligible; about 50 patients have stayed for more than 5 years in the hospital, about 50 patients have stayed between 1-5 years and about 300 patients stay under 1 year (230 male and 70 female). The average duration of stay is about 8-10 weeks with about 30% of them as repeat admissions. The reasons given for repeat



admission is discontinuation of medication, lack of family supervision and resources and poor social supports and stigma. Discharge problems occur due to poor family education and tolerance and lack of social support system. This is countered by adequate family education, counseling and assurance of admission whenever there is a relapse or problems. Other than for reception cases, the police are not involved, as there is liaison with NGOs'. The patients are informed of their rights and have a right to appeal through the staff nurses or physician in case of grievances.

## **Finance**

The plan budget has steadily increased in the last few years and currently is about 10 lakhs. The non-plan budget is over Rs one crore. Of this about 75% goes for staff salaries, 17% for food and linen for patients and 2% for medicines. The authorities find the budget inadequate.

## **SERVICES**

### **Casualty and emergency service**

The hospital does not have casualty and emergency services or short stay wards. If acute psychotic patients are brought disturbed they are admitted directly to the closed wards by the duty doctor. The hospital has one ambulance, telephone service and routine investigation services are available on emergency basis. Specialist medical consultation is available at the district civil hospital. The casualty and emergency service is inadequate and staff need to be posted for this service.

### **Outpatient service**

There is a daily outpatient service working from 8AM-12Noon and 3-5 P.M. About 40 patients are seen per day and 1-2 are brought as emergency cases, sometimes chained or roped. The staff posted to the OPD are 2 psychiatrists, 12 general Medical Officers, 1 psychiatric social worker, 19 general nurses, 1 technician, 6 administrative staff and 4 attenders and peons. Patients wait about 1-2 hours and new cases are seen for 30-60 minutes and follow-ups for about 10-15 minutes. There are 4 interview rooms, a writing hall with adequate seating arrangements and free medicines are given for upto 3 weeks for about 25% of the patients. There are no charges for the OP services.

### **Inpatient service**

The inpatient services comprise of only closed wards with fairly adequate services. Cleaning and baths occur daily and linen is changed weekly. Each patient has adequate living space, cot, mattress, linen, clothes, blankets and pillows. Though uniforms are present, patients are permitted to wear their own clothes. All basic



ward facilities are present like toilets, fans, recreational facilities and lockers. The barber is present daily and anti lice and bug measures (with Deltamethrine) are adopted fortnightly. There are duty rooms and emergency facilities in the ward. About 15% are paying patients. Seclusion wards are present but rarely used. Family members are permitted to visit daily. Open wards with facilities for relatives to stay should be organized. Free diet is given at Rs30/-per day and running water is available. Food is brought in hygienic containers and served in plates and cups in the dining hall or verandah. There is no dietitian or modern kitchen facility.

The hospital has only routine blood and urine lab tests in the inpatient setup. There are no other specialized tests and no investigation facilities at all in the Out Patient Department. There are no psychological investigation facilities. Drug therapy and direct ECTs' are available as treatment. Basic psychotherapy and counseling is available but there are no behavior therapy or rehabilitation facilities. Violent patients are controlled with a combination of physical restraint, seclusion and drug therapy.

There are separate case files for each patient and these are easily retrieved. All papers and records are maintained in one file per patient and this available only to the treating team. Support services like electricity, water, drainage, library and recreational facilities are available though not adequate. There are no canteen or telephone facilities for patients or family members. There are no rehabilitation services except a long stay facility.

### **Community services**

There are also no regular community services except for occasional health camps. Plans have been made to implement the District Mental Health Program and to train the necessary staff.

### **Rights and Legal Aspects**

There is a Board of Visitors as prescribed in the State Mental Health rules and a Board of Administration as suggested by the Supreme Court orders. The psychiatrists do the decertification and there are hardly any admissions or discharges involving legal procedures. The Mental Health Act, 1987 is fully complied with though there are problems in implementation due to inadequate manpower.

There are no complaints of patient ill treatment lodged in the courts, though there is public interest litigation in the Supreme Court. The patient and relatives are informed of their rights and all procedures (like admission & discharge) are carried out after a written informed consent. The staff members are also aware of the rights as they treat patients with respect, kindness and dignity.



## Summary

This hospital ranks among the better Government hospitals in India. This is a good example of how hospitals can be improved from within if there is a will and cohesion among the staff members. This hospital was overcrowded and in a bad condition about 10 years ago. The changes have been made gradually with great perseverance over the last 5 to 7 years after a young psychiatrist from NIMHANS headed the hospital as the superintendent. He could not have achieved it but for the support and help from all his staff especially the ward attenders. This hospital is also testimony to what happens if the Mental Health Act is fully implemented and the changes set out in the Act are enforced. Besides this, the process of early discharges, good outpatient follow-ups and acceptance of patients by family members was achieved by psycho-education with relatives. The conditions in the ward have improved with the efforts made by the staff in terms of daily activities and cleanliness. The authorities (namely the NEC and Government of Assam) have suggested that the hospital be converted into an autonomous regional institute of mental health on the lines of NIMHANS. This has been implemented at the time of writing of this report.

## SUGGESTIONS

- There is an urgent need to increase the hospital beds in the whole state, as the current position is too meagre for the population. It is better to have smaller hospitals in many areas as it is difficult to travel from place to place.
- Implementation of the NMHP and posting psychiatrist in the district hospitals will make it easier to cater to the larger area.
- Emergency services and open wards with provision for family members to stay will raise the standard of this hospital.
- Quality psychiatric care in terms of modern drugs, modified ECT and psychosocial treatments in wards and OPD must be followed.
- There is ample space for the starting of rehabilitation facilities such as horticulture for the ward patients.
- Better laboratory facilities for essential investigations are needed in the outpatient services. These should be provided.
- Support services like kitchen, laundry, pharmacy, stores and maintenance should be improved.
- There should be separate wards for medical emergencies, children, Open and special wards should also be built.



- There should be recreational facilities available in each wards.
- The hospital should be made into a teaching hospital with postgraduate students posted in the wards.



# CHAPTER-17

## BIHAR

### INTRODUCTION

Bihar is one of the medium sized states in the country being the ninth in area. In population, it is the second biggest state. The State of Bihar is spread over an area of 173,877 square kilometers. Bihar is squeezed in between West Bengal, Orissa, Madhyapradesh and Uttarpradesh. It reaches up to the Himalayas in the north and is completely landlocked. Bihar is bound by Nepal on the north, on the south by Orissa, and on the east by West Bengal and on the west by Madhyapradesh and Uttarpradesh. The state has 55 districts and a total population of 86,374,465 (1991). The density of persons per square kilometer is 497. The literacy rate is about 38.54. Bihar has a unique feature with respect to provision of mental health services. Kanke, ten kilometers away from Ranchi has three mental hospitals. One is being run by the Government of India, the second by the Bihar State Government and the third, the Davis Institute of Psychiatry is a private facility. All the three are situated within a four to five square kilometer area. In addition there is general hospital psychiatric unit facility in the medical college hospital at Ranchi.

### CENTRAL INSTITUTE OF PSYCHIATRY, RANCHI

#### Background

The Central Institute of Psychiatry (CIP), Ranchi is a Government of India institution and it functions under the administrative control of the Directorate General of Health Services and the Ministry of Health and Family Welfare, New Delhi. It is at Kanke at a distance of about 10 kms from Ranchi City. The British established this hospital on 17 May 1918 and named it the Ranchi European Lunatic Asylum. It could then accommodate 174 patients, 92 males and 82 females and was meant exclusively for the European mental patients. It was under the direct control and management of the Government of Bihar. In 1922, it was put under the control of a Board of Trustees with various participating Governments represented in the Board and in the same year, its name was changed to European Mental Hospital. The year 1922 was also notable for the fact that the institute obtained affiliation to the University of London for the Diploma in Psychological Medicine examination.

In 1948 when the country became independent, racial segregation was abolished and the hospital was also open to Indian patients. The hospital was renamed the Inter-Provincial Mental Hospital. In 1952, it was renamed as the Hospital for



Mental Diseases. On first June 1954, the Board of Trustees was abolished and the Government of India, Ministry of Health took over the administration of the Institute. On April 1, 1977, it was raised to the status of an Institute and was named as Central Institute of Psychiatry.

At one time this facility was considered the premier centre for mental health in the country. It was the first to establish an Occupational Therapy Department in 1922 and an Electro Encephalography Department in 1949. It also pioneered the use of lithium and chlorpromazine. The Institute has a sprawling campus spread of about 400 acres.

### **Hospital infrastructure**

The hospital is spread over 90 acres of land. It is enclosed by huge walls with large entrance and exit gates resembling that of a jail. There are 16 wards, 9 for the male and 6 wards for the female patients and one family unit. Each ward is at some distance from the other wards. The wards are of pavilion type, built during the British Raj and each ward has well laid out roads and lawns around it. The entire grounds of the hospital are full of lush green trees, some of rare variety. A high wall separates male and female sections. All the wards are named after eminent psychiatrists and physicians of the world. Outside the hospital boundary walls, the family wards functions in four cottages. There is one ward for children, which admits both boys and girls and is by the side of the family unit. Alcohol and drug unit is under construction. There is no separate criminal ward. Inside the high wall barricade, the hospital is an open type and the patients are not confined to the rooms but are free to go around the hospital. Seclusion wards and single cells are present but not used.

It is noteworthy that in this hospital there is no free inpatient treatment. Charges are fixed for different slabs of income. The bed capacity currently is 643. Various State Governments and Agencies have reserved quotas of beds in the hospital; Central Government=13, West Bengal=260 which is now withdrawn, Uttar Pradesh=25, Arunachal Pradesh=15, Assam=10, Punjab=01, Bihar=50, Nagaland=27, Tripura=21, Manipur=11, Himachal Pradesh=10, Coal India=12 and Independent category=188. The basic facility available in the general category includes cot, mattress, blanket and warm clothes during winter.

The Director, currently a non-psychiatrist heads the administration. The Additional Director, teaching faculty and the Nursing Superintendent assist him. The buildings are very old and are not properly maintained. All the buildings are Government buildings and are maintained by Central Public Works Department. Wards do not fulfill the modern nursing needs. There is lack of privacy, shortage of bathrooms, recreation rooms etc.,



## **Staffing pattern**

The total number of existing staff of all categories is 479. Apart from this, there are 139 vacancies. There are 64 members at the level of faculty and medical officers. There are 144 nurses in different categories. The occupational therapy department has a staff of 27. Ward attenders and peons constitute 39% of the total staff. Technicians and supportive staff are 77 in number.

The staff are qualified and are given special training. The work study unit from the Ministry of Health and Family Welfare (reference No. A.11013/2/88-NMC (PH) dated 27.12.95 and even No. dated 24.1.96) had recommended creation / abolition of posts and the recommendations are yet to be implemented.

A meeting of all categories of the staff takes place once in a year. In service training programs are held for the medical and non-medical staff. Staff burn out is reported among ten percent, mainly due to monotony, lack of stimulation and inadequate leave provision for the teaching staff.

## **Admission and discharge procedure**

Admission and discharge procedures are governed by the Indian Lunacy Act, 1912. The admitting authorities are the Psychiatrist and the Judiciary. Voluntary admissions over the last five years range around 1800 and an almost equal number of discharges have been occurring. Death rate is reported to be 0.42 percent. One hundred and seventy nine escapes were reported in the past five years. Fifty percent of the patients are staying for 2 years and more. Average duration of stay is reported to be 68 days. Approximately 17% of repeat admissions are reported. Board of visitors carries out the decertification. Discharged involuntary patients are sent with relatives or alone. Reluctance of guardians to take back the patients, discharge of patients from other states that have to be done by the police and unpaid dues of patients are some of the reasons for discharge problems.

## **Finance**

The budgetary allocation is adequate and separate accounts are reported to be maintained for various funds. A major proportion of the finance is spent towards the salaries for the staff, followed by food for patients, drugs and others.

## **SERVICES**

### **Casualty and emergency service**

Casualty and emergency services are present and are easily accessible. It is reported that 40 patients per week are attended to in the casualty. Acute psychosis,



alcoholic psychosis, delirium, catatonic schizophrenia and manic episode are the types of cases that present at the casualty services. Among those who attend the casualty service, forty percent are admitted to the wards and the rest are treated on an out patient basis. There is a short stay ward with a capacity of sixteen beds. There are two roadworthy ambulances which are available 24 hours. The minimal required medicines are stocked in sufficient quantity in the casualty and ECG facility is available, and for specialist services, the patients are usually referred to the general hospital. Staff in the casualty are adequate. Facilities in the casualty are inadequate.

### **Outpatient service**

Daily outpatient services are present and functions between 8.30 am to 1.00 pm and 2.00 to 4.00 pm. On an average, 80 patients are seen every day. There are seven interview rooms in the OPD, which are insufficient. New cases are seen over 90 minutes and each subsequent visit is allotted 15 minutes. The average waiting time is reported to be three hours. Facilities in the out patient department are inadequate. Additional staff, especially clinical psychologists and psychiatric social workers are required.

### **Inpatient service**

Inpatient activities start at 6.30 a.m. and end at 9 p.m. everyday. Inpatient wards are well maintained. Patients have cold water bath in the open water bathtubs outside the wards even during the winter season. Frequency of dress change occurs once in three days and linen once a week. Warm clothes, pillows and towels are insufficient. The patients are allowed to wear their own dresses though specific uniforms are available for males and females.

The basic facilities in the wards for the patients are inadequate. Plinth area per patient is approximately twenty square feet in the wards. There is only one toilet for every six to seven patients. There is no separate provision for the patients to keep their belongings. Adequate recreational facilities are present for the patients in and around the wards. Hair cutting and face shaving facility are present for the male patients. Anti-lice and anti mosquito measures are provided. Visitors are allowed from morning till evening.

### **Dietary and pantry facility**

The hospital has a well-equipped and well maintained pantry and dining room. There are separate dining rooms for the males and females. The caloric supply of the food is adequate. Food cost per patient per day is Rs. 36.46 for non-vegetarians and Rs. 31.19 for vegetarians. Food supply to the wards is in closed containers by the attenders. Food is prepared using gas as well as firewood under the supervision of the dietician.



## **Investigation and treatment facility**

The pathology and biochemistry laboratories are very well equipped. It has an autoanalyser capable of doing 180 tests per hour including drug assay and hormonal measurement. There is a high performance liquid chromatography system for carrying out research in biological psychiatry. All routine investigations are available for the in-patients. There is no HIV screening and Hepatitis B investigation facility.

Clinical psychology laboratory is well equipped. It was started in 1949 and it happens to be the first laboratory in the country. Psychosocial interventions include home visits and collateral contacts for the in-patients only.

Direct Electro Convulsive Therapy is performed in the institution. Violent patients are brought under control by using a combination of drugs and ECTs.

## **Medical records**

There are separate case files for each patient and retrieval of the files is reported to be within ten minutes. A total number of 50,000 case files are being maintained by the Institution. Of this, 20% of the files are not retrievable. Access of the patient records is only to the treatment team and confidentiality of case records are maintained. There is a need for medical record officer, increase in medical record technicians and medical record attendants. Computerization of medical records of OP and IP and could reduce missing and duplication of files.

## **Rights of the patients**

Not all the staffs are aware of the rights of the mentally ill. Discharged patients are followed up at the outpatient department level. No systematic program is available for them. There is collaboration or liaison between the hospital and other social agencies or schools and college. Patients are allowed to write letters to their families and 10% do avail of such services. The staff needs to be sensitized about the rights of the mentally ill through workshops and seminars.

## **Services and facilities**

Water, electricity and drainage facilities in the hospital campus are inadequate. Though generator facility is available, it is not able to cater to the total need of the hospital. There is a canteen run by the patients themselves, which is inadequate to cater to the needs of the hospital population. There is no canteen service available in the outpatient department.

Library facility for the patient is present with about 3000 books. Regular supply of newspapers and magazines are present. The library for the staff and students has a rare and fine collection of books and journals. Electronic medical literature is



also available. One hundred and twenty journals are subscribed to every year. Recreational, social and religious facilities for the patients are available within the premises.

### **Board of visitors \ Management**

Board of visitors is present with six representatives and the Indian Lunacy Act, 1912 is still adopted. The Board of visitors meets once a month. Mental Health Act is not complied due to the non-implementation of the statutory requirement by the Bihar government.

### **Rehabilitation services**

The hospital has a separate section for rehabilitation and vocational training unit. It is India's oldest occupational therapy department started in 1922. Fourteen vocational sections are present with a sheltered workshop where in printing, book-binding, envelope making, file making and register binding are carried out.

There is a separate rehabilitation ward. The bed strength of the same is fifty and it currently has 26 patients. The patients are paid an incentive of Rs. 2/= to Rs.5/= every month. There is no placement service outside the hospital. There is no participation by volunteers or families in the rehabilitation activities of the hospital. The occupational therapy unit should be strengthened. Payment made to patients as incentive needs to be increased. Improved patients need to be placed in the community.

### **Community services**

Once a month a team of doctors visits West Bokaro Colliery and provide psychiatric services. On an average, 60 patients are managed in these clinics. The local doctors have been trained to carry out the follow-up and other activities. No other community activity is carried out due to lack of manpower, funds and vehicle.

### **Court representation and orders**

There are no court representations or patient ill treatment complaints lodged with any authorities. Problems with Magistrate cases in admission and discharge are negligible, as the proportion of cases represented from this source is very less.

### **Adequacy of care**

Biological methods of treatment are adequate. Direct ECT use needs to be replaced with modified ECT procedure. Non biological methods of treatment like psychotherapy, group therapy, behavior therapy, guidance and counseling are inadequate for lack of faculty in Clinical Psychology and Psychiatric Social Work Departments.



## SUGGESTIONS

- The Director or Medical Superintendent of the mental health institution should be a Psychiatrist.
- The recommendations of the work study committee in terms of creation and abolition of posts should be implemented.
- Routine investigation facilities and biochemical investigations should be made available to the casualty and OP department.
- Improvement of OPD services with adequate number of mental health professionals and additional staff for service provision should be done.
- Modified Electro Convulsive Therapy should be routinely administered.
- There is a need for a medical record officer, increase in the number of medical record technicians and medical record attendants. Computerization of medical records of OP and IP and could reduce missing and duplication of files.
- The staff should be sensitized about the rights of the mentally ill through workshops and seminars.
- The Mental Health Act, 1987, should be complied with immediately. The Bihar government should satisfy the statutory requirement to implement the Mental Health Act and constitute the State mental health authority, licensing authority, the mental health inspectors etc.
- The occupational therapy unit should be strengthened with greater emphasis on placement of improved patients in the community.
- There is a need to extend mental health care services to the community. The mental health team should comprise of psychiatrist, clinical psychologist, psychiatric social worker and psychiatric nurse.
- A vehicle for mobility for community service is a necessity.

## RANCHI INSTITUTE OF NEURO PSYCHIATRY AND ALLIED SCIENCES

### Background

The earliest lunatic asylum in Bihar was in Monghyr near the court premises south of the Ganges River. It was established in 1795 A.D. It was closed on 1.11.1821 and the patients were shifted to Patna. Later, a search for idyllic surrounding for mental patients began and Ranchi was selected as a suitable place. Kanke was selected as the final location as Namkum residents were antagonistic to establishing a



mental hospital near their place of residence. The nomenclature lunatic asylum changed to mental hospital in 1922. Indian Mental Hospital was opened in the last week of April 1925 in the present site. Captain J.E. Dhanjibhay was the first Superintendent. The male wing started functioning on 4 September 1995 with 110 patients from Patna. The female wing started functioning with 53 patients on 19 September 1925. Gradually patients from Dacca (Bangladesh) and Berhampur (Orissa) were transferred here. There were 1226 patients on 31 December 1925.

The name Ranchi Manasik Arogyashala (RMA) was given on 30<sup>th</sup> August 1958. Patients from the States of Eastern India e.g., Bihar, West Bengal, Orissa, Manipur, Mizoram, Tirupura and other displaced persons were lodged here. The Government of Bihar notified R.M.A. as an autonomous body vide notification No.424 (10) dated 29 September 1994. Dr. P.S. Gopinath took over as the first Director of autonomous R.M.A. RMA is currently known as Ranchi Institute of Neuro Psychiatry and Allied Sciences – RINPAS. The hospital is situated 8 kilometers away from Ranchi.

### **Hospital infrastructure**

The architecture of the hospital is more of a jail. Huge walls surround the entire hospital area. The entrance is closed like any other jails in the country and manned by the security. The families cannot visit the patient in the wards. The patient is brought near the gate to a small cubicle to meet the family. A big road separates the male and the female wards. On the left side of the Ranchi – Kanke main road is the inpatient facilities for the males and on the right is the inpatient facility for the females. There are 15 closed wards, 11 for the males and four for the females. There are no open, paying, family or children wards. There are two criminal wards in the male side and 'one staff ward'. Among the closed wards, there is an isolation and alcohol and drug ward.

The basic facilities present in the general category include cots, mattresses, pillows, and rugs. The hospital has introduced colored printed linen to give a non-hospital look inside the wards. Mosquito mats are provided to most of the patients.

The total bed strength has been reduced to 600. The current occupancy is about 575. The administration of the hospital is under the Director of the Institution. He is supported by the Establishment section, Nursing Matron, Medical Superintendent, Accounts Officer, Deputy Director of PWD and the Academic Departments. The hospital is spread over a very vast area and the buildings belong to the Government. The Public Works Department is responsible for the maintenance of the hospital infrastructure. The buildings are very old. The Hospital Management Committee is currently renovating some of the structures. There is no proper storm water drainage system inside the hospital. Toilets, bathrooms, duty rooms are not properly maintained and have poor electricity and insufficient water supply.



## **Staffing pattern**

There are eight qualified psychiatrists, and five vacancies against the total sanctioned strength of thirteen. There are six general duty medical officers cum specialists. Of the total seven and six sanctioned posts of clinical psychologist and psychiatric social workers respectively, only four and one are currently occupied. Of the total 133 sanctioned general nurses, only 58 are occupied and 56% vacancy is noted in this category alone. There are no administrative staffs against the seven existing posts. There is only one occupational therapist and two lab technicians. There are six regular consultants in the disciplines of Neurology, Medicine, Ophthalmology, Dentistry, Pediatrics and Chest Medicine. One dental surgeon is on the regular staff of the hospital.

The hospital working hours are from 8.00 a.m. to 5 p.m. The members of the lower level staff are not trained except for 26 warders. Seventy-five male nursing assistants were recruited for better patient care.

## **Admission and discharge**

Admission and discharge procedures are governed by the Mental Health Act, 1987. The patients are registered in the outpatient department. The admitting authorities are the psychiatrist and the judiciary. There is a sharp decline in voluntary admission. From 4105 in 1992, it has come to 1360 in 1996. Admissions through court have increased and were about 142 in 1996. The rate of discharge shows an upward trend and during the period 1996 to 1998, a large number of patients were discharged. Death rate is around 2.2% over the past five years. Number of suicide per year has been one. Escape over the last five years is reportedly 466. On an average around 80 patients, escape every year. It is reported that the patients escape by climbing the trees and jumping over the high wall. Sixty four percent of the patients are staying in the hospital for more than two years upto a maximum of above fifteen years. The average duration stay reported as sixty days. Fifty percent of the total admissions are repeat admissions. The reasons reported for repeat admissions are poor drug compliance, family not willing to take the patient back and episodic illness.

The hospital authorities decertify the regular patients. Involuntary admissions are discharged and sent home with police escort. The police department facilitates the discharge of patients.

## **Finance**

The non-plan budgetary allocation for the period 1994 through 1996 is above 400 lakhs. Of this, 79.56% for the year 1996 has been spent on salaries. Drugs constitute around 3% of the total budget. Food for patients costs around 10% of the



budget allocation. Reportedly, separate accounts are maintained for various funds. The budgetary allocation has been reported as inadequate.

## **SERVICES**

### **Casualty and emergency service**

Though present is not easily accessible. An average number of 10-12 emergencies are reported every week. Of these, 40% are admitted immediately and are predominantly cases of bipolar affective disorder or acute psychosis. There is a short stay ward with four beds. Ambulance facility though present is an old one. Basic investigation facilities are available in the casualty and minimal required drugs are stocked. Referral service to the Medical College hospital is present in case of emergency.

### **Outpatient service**

Daily outpatient services are present between 8.30 am to 4.00 p.m. About 30-40 cases are seen per day. Around three patients are brought chained every day. There are six interview rooms and a waiting hall with a seating capacity for about fifty persons. The arrangements in the outpatient department are average. All drugs are distributed free of cost. Registration charge of Rs.15/= per patient is collected.

### **Inpatient service**

The inpatient wards are reportedly cleaned every day. Patients are given bath daily and the dresses are changed once in two days. Linen change is reported to be once in a week. Plinth area per patient is approximately thirty square feet. Cots, mattresses, linen, pillows, warm clothes though available in the wards, is not in stock at the central stores. Most of the cots are unserviceable and need replacement. Warm clothes are available for the patients. The patients are not allowed to wear their own dress and are provided a uniform. The hospital authorities report that the uniform helps in reducing the number of escapes and in identification of such patients. White pajama and kurtha are the uniform for the males. Females are provided with pink and gray saris and nighties. Three sets of uniform are available per patient.

Basic facility for the patients in the wards range from one toilet per five patients. Cots are adequate. There is no privacy for the patient in the ward. Recreational facilities like carom boards are available in the wards. The old kitchen has been converted into a library for the inmates. Common facilities for keeping the belongings of the patient are available. Patients' weights and female patient's menstruation charts are maintained. Barber facility is present in the wards twice a week. Anti lice and mosquito measures are adopted in the wards. All the patients are non paying. There are four seclusion wards in each ward and are reportedly used occasionally. There is no duty room in the wards.



## **Dietary and pantry service**

The dietician is in charge of the food preparation. The budgetary allocation for food has increased from Rs. 40 lakhs to 51.46 lakhs. The cost of diet rate per patient is Rs.30 per day and free diet is provided to all patients. Less than 5% of the patient are provided with special diet depending on the instruction of the physician. Total calorie supply per patient is 3322. Tea and milk are supplied to the patients. Breakfast, lunch and dinner are supplied in the wards and in the dining hall. The dinner is served at 5 p.m. and breakfast at 8.30 a.m. This results in the patients being on an empty stomach for long hours till the morning. Water supply is through taps and steel containers in the wards. Adequate containers for carrying food are available. Food is served to the patients in thalis. Food is prepared in hygienic condition using gas.

## **Investigation and treatment facilities**

A new diagnostic lab with modern facilities is available. EEG, ECG and Bio-feed back equipment has been started from February 1998. A separate generator set has been installed. All routine investigation facilities are available for the inpatient. There is no HIV screening or Hepatitis B investigation in the hospital. All psychosocial intervention facilities are available. Investigations and assessments are free of cost. Investigation facilities are available during routine working hours. Direct ECT is administered in the inpatient wards. Violent patients are very rarely secluded.

## **Medical records**

Individual case files are maintained for each patient and a total number of 100,000 case files are being maintained. Four staffs are handling the medical records without a trained medical record officer.

Average time taken to retrieve the file is reportedly 5-10 minutes. Access of case file is limited to the treatment team alone. Confidentiality of the records is maintained. Record maintenance is not adequate due to absence of trained personnel. Data storage or analysis is not carried out due to non-existence of bio medical statistician.

## **Rights of patients**

It is reported that all the family members are explained about the nature of illness, treatment and prognosis. The family members are not allowed to see the patients in wards and are allowed only outside the campus or in the outpatient department. This prevents the family members taking the patient outside or to take part in certain other activities of the hospital. The only program that exists for the family is that of the counseling both at the time of admission and discharge.



Only 10% of the patients are allowed to write letters to their home. The doctor or the social worker screens all the letters written by the patient to their family. The patients are not allowed to talk to recognized social agency personnel.

There is no liaison with NSS, schools, colleges or any other agency. Very few of the staff are aware of the rights of the mentally ill.

### **Board of visitors \ Management**

The medical board constituted for the purpose carries out decertification. There is no board of visitors. A Board of Management with nine members manages the hospital with the Director of, RINPAS as the Member Secretary. The bylaws of the management committee are currently being framed. The Board of Management meets once in four months. Five to ten percent of all admissions involve legal procedure and 2% of all readmission involve legal procedures. Mental Health Act of 1987 is reportedly fully complied by the hospital.

### **Rehabilitation services**

There is a separate section for vocational training in the hospital. Carpet weaving, tailoring, welding and carpentry are the various sections available in the hospital. Towels, bed sheets and carpets manufactured here are purchased by the hospital or sold in auction. Clothes for the hospital are stitched in the occupational therapy unit itself. The intake capacity of the rehabilitation section is approximately 40 but only 20 are currently availing the facility. As a part of rehabilitation activities, patients are routinely used for hospital work and are paid very meager incentives. There is inadequacy of trained staff. Buildings are poorly maintained and the equipment is very old.

### **Community services**

There are no community outreach programs currently. Facilities for training non-mental health professionals though present are not carried out. Orientation programs for psychology, social work and nursing students are carried out. Inadequate trained manpower and non-availability of vehicle are stated as the reasons for not carrying out community outreach programs.

### **Staff training**

Once a month meeting of all categories of staffs is conducted. Regular academic programs including seminars, case conferences are conducted. Burn out is reported as sixty to seventy percent in class IV and forty percent in Class III staff. They are not motivated for work. The main reasons for the same are lack of education and training, low promotional avenues, corrupt practices, indiscipline and a lack of strict disciplinary action against erring employees.



## **Court representations and orders**

The major public interest litigation of Writ Petition (Civil) No.339 (1986) between Rakesh Chandra Narayanan vs. the State of Bihar and others was filed in 1986. Based on the above complaint, the Supreme Court vide its letter Bo.535465 dated 17.5.1994 made the institution autonomous and gave directions for its running. The National Human Rights Commission is monitoring the compliance to the Supreme Court order.

## **Adequacy of care**

The hospital authorities have outlined a number of activities for improving the quality of care of the mentally ill. These include the need for clinical psychologists, psychiatric social workers and regular ward rounds by the treating team. Nursing care should be available round the clock. Training of the group C and D staff in the area of mental health should be provided. Effective rehabilitation services, introduction of community outreach program and starting of special clinics for varied conditions have also been suggested.

## **Summary**

Subsequent to the Supreme Court Directions and monitoring of the National Human Rights Commission a major change has taken place in the quality assurance of mentally ill in this hospital. The presence of the current Director who is a psychiatrist and a retired army Colonel has brought about several changes. If the number of mental health specialists is increased and the problems at the Group D level are sorted out, these changes are likely to be stable. There is an urgent need to restart the training program in psychiatry.

## **Suggestions**

- Electricity, water supply, construction, repair and maintenance should be under the direct control of the Institutional Head and the Management Committee. A separate cell for the same is needed with a representative from the P.W.D.
- Maintenance of the Estate should be under a separate Estate management Committee of the hospital.
- Gross inadequacy in the staff pattern in terms of vacancies in the mental health team including psychiatrist, clinical psychologists, psychiatric social workers and psychiatric nurses should be filled up.
- Improved long stay persons in the hospital should be discharged back to their homes with the help of the police and judiciary.



- Basic amenities for the patient in the wards like better water supply, electricity, drinking water and furniture should be provided or improved.
- The hospital should have open ward facility wherein family members can stay along with the patient. Further, family members should be encouraged and allowed to visit the patients in the wards rather than outside the hospital.
- Workshops for staff of the mental hospital relating to mental health and rights of the mentally ill are necessary.
- There is an urgent need to set up half way homes in the neighborhood and strengthen the rehabilitation and vocational training unit.
- Community mental health services should be started at the earliest.

### **Suggestions for the State**

- The Director or Medical Superintendent of the mental health institutes should be a psychiatrist.
- Gross inadequacy in the staff pattern and vacancies in the mental health team including posts of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses should be filled up. The recommendations of the Work Study Unit of Ministry of Health and Family Welfare with reference to the terms of creation and abolition of posts should be implemented.
- OPD services should be improved.
- Modified ECTs should be administered.
- The Mental Health Act should be immediately implemented. The Bihar government must satisfy the statutory requirement to implement the Mental Health Act.
- The occupational therapy unit should be strengthened and improved patients should be placed in the community. The amount of incentives paid to the patients should be increased.
- There is a need to extend mental health care services to the community. Vehicle to ensure mobility for community services is a necessity.
- Electricity, water supply, construction, repair and maintainence should be under direct control of Institutional Head and the Management Committee. A separate cell for the same is needed with a representative from the P.W.D..



- Maintenance of the Estate should be under a separate Estate management Committee of the hospital.
- Improved long stay patients should be discharged back to their homes with the help of the police and judiciary.
- Both the hospitals should have open ward facility wherein family members could stay along with the patient.



# **CHAPTER-18**

## **DELHI**

### **INTRODUCTION**

As a national capital Delhi is likely to emerge as the most populous Indian city by the year 2010. The present population is 93 Lakhs. It consists of Delhi and New Delhi. It is the commercial hub of northern India. It is the largest center of small-scale industries of all kinds. Delhi has many universities and educational institutes like Jawaharlal Nehru University, Jamia Milia Islamia, All India Institute of Medical Sciences, Indian Agricultural Research Institute, Indian Institute of Technology, Indira Gandhi National Open University, Jamia Humdard University, National Museum Institute Of Art Conservation and Museology and the Delhi School of Planning and Architecture.

There are 4 medical colleges including the prestigious All India Institute of Medical Sciences (AIIMS) which conducts various undergraduate and postgraduate courses in various specialties. All the medical colleges have psychiatry departments. There are more than 150 private psychiatrists practicing in the city of Delhi. The State-run Institute of Human Behavior and Allied Sciences provides mental health services.

### **INSTITUTE OF HUMAN BEHAVIOR AND ALLIED SCIENCES (IHBAS), DELHI**

#### **Background**

The mental hospital, Shahadra, was established in 1966. It is located 10 km away from the city center. It became an autonomous Institute (IHBAS) in 1993. In response to a public interest litigation the Supreme Court directed the Government of India to convert the Shahadra Mental Hospital to a modern Institute on the lines of NIMHANS, Bangalore. The Government of India provided Rs. 30 crores to the Government of Delhi for the above said purpose. It is in the process of changing from a mental asylum to a modern psychiatric institute.

#### **Infrastructure**

The hospital has 100 acres of land. The hospital has a modern look with a new outpatient and administrative block with a beautiful garden in front of it. However, it has a tall wall at the back and on the sides. The wards and toilets are getting



renovated. Many old wards are closed and will be demolished. It has become a teaching, training and research center.

### **Staff pattern**

The staff members consist of one Director (non psychiatrist), 6 qualified psychiatrists, 10 senior residents, 20 general medical officers, junior residents (PG students), one clinical psychologist, 4 psychiatric/medical social workers, 37 general nurses and one occupational therapist. House keeping, security and ward attenders jobs have been given to private agencies.

### **SERVICES**

#### **Casualty and emergency service**

Round the clock casualty and emergency services with ambulance facility is available. These facilities are well organized.

#### **Outpatient service**

The new outpatient department has a registration counter, a waiting hall, examination rooms, drug dispensary and a follow-up counter. Around 150 patients attend the OPD services. Outpatient services include psychiatric and neurological services. Free drugs are dispensed for all the patients. The outpatient services are conducted daily and are well organized. The outpatient timing is from 8.30am to 1.00pm daily. Free drugs, lab facilities, casualty and emergency services are given round the clock, Medical records are well maintained.

#### **Inpatient service**

The hospital has a bed strength of 400. The wards and toilets are getting renovated. The old rehabilitation ward is getting a facelift. About 300 patients were discharged and sent to their homes. Now 100-150 patients are remaining in the wards. Many old wards have been renovated and look modern. Only a quarter of the sanctioned beds are used at present. The general maintenance of the wards is adequate. A separate ward for neurological patients has been started. Majority of the (80 – 90%) admissions are voluntary and the rest are by court order. Average duration of stay is for 25 days. Relatives are encouraged to stay with their patients. Water supply and lighting in the wards are sufficient. Toilet facilities are adequate. Each patient has a cot and mattress and supply of fresh linen is adequate.

Patients are allowed to wear their own clothes. Hospital uniforms are also provided for those who do not have their own clothes.. Vocational training facilities are inadequate. Kitchen and dietary services are very good. Rs 18/- per patient per



day is spent on diet. Quality and quantity of the food given to the inpatients is good. Routine investigations and special investigations like Serum lithium estimations are present. Modified electro convulsive therapy is given regularly. Though a separate occupational therapy building is available it is underutilized. A good physiotherapy section is functioning in this hospital. Recreational activities are present but are inadequate

## **Legal issues and community participation**

The Board of visitors meets once a month and consists of internal members. Discharge issues are discussed. Staff members and patients are not adequately oriented to the rights of the mentally ill. Involvement of NGOs or volunteers on a regular basis is not there. Recently community mental health activities have been started.

Steps have been taken to develop this into a teaching institution. As a beginning they have started training for Diplomate of the National Board Exams. There are plans to start specialty sections like de-addiction, child guidance and mental retardation clinics.

## **Summary**

The progress made in converting a traditional mental hospital into a modern mental health institute within a period of five years appears to be very satisfactory. The institute can be a model for other mental hospitals in the region.

- The institute has prepared a master plan and has taken up the implementation of the same in a phased manner. This should be completed within the time frame.
- Community based programs like satellite / extension clinics and school and college mental health programs should be started. The involvement of NGOs in organizing services should be encouraged.
- Child psychiatry, Family wards, Mental Retardation clinic and other special services should be started.
- The inpatient facilities should be further improved.
- Psychosocial rehabilitation should be taken up in a systematic manner and greater emphasis needs to be given to this important area.



# CHAPTER-19

## GOA

### INTRODUCTION

Goa is the smallest state of the Indian Union. Goa and its adjoining areas of Daman and Diu were liberated from Portuguese Colonial rule in 1961. It was part of the Union Territory of Goa, Daman and Diu, until it became the 25<sup>th</sup> state in the Indian Union on May 30, 1987, while Daman and Diu remained part of the Union Territories, under an administrator.

Goa is situated between the states of Karnataka and Maharashtra. It has an area of 3702 sq.km. Its capital is Panaji. Female to male ratio is 969:1000. The population is a little even a million. It has two districts. Goa has a relatively high literacy rate of 76.96 and a per capita income of Rs 6939. Konkani and Marathi are the main languages spoken in Goa. Goa is well known for its tourism and relics of Portuguese influence.

### INSTITUTE OF PSYCHIATRY AND HUMAN BEHAVIOUR, GOA

#### Background

Goa is one of the centers which has a long tradition of psychiatric services, dating back to the Portuguese, who started the mental asylum at Chimbél. In 1957, a new mental hospital was built at Altinho in Panaji, and known as the Abade Faria Mental Hospital. In 1950, as WHO consultant, Dr. M.V Govindaswamy was deputed to advise the Portuguese Government on the mental health services in Goa and on the organisation of the 'new' mental hospital (Abade Faria). His letter to the Provedor da Assitenica Publica contained recommendations for the hospital.

Some of the additions and alterations he suggested were:

- Lowering of the compound wall ("No modern mental hospital is enclosed by a high compound wall").
- Better integration between the two male and two female ward blocks.
- Rooms for private patients
- Verandahs to double as day rooms and dining rooms
- Separate treatment rooms for specialized forms of treatment.
- Conversion of one out of two blocks meant for acute and disturbed pa-



tients for criminals and lunatic alcoholics (“but all bars and cages should be removed as well as all vestiges reminding one of jails and prisons”).

- A new administrative building.
- A child guidance clinic and psychiatric unit.
- Residential quarters for staff.
- Acquisition of 100 acres of ground for further development, especially provision of farms and industrial workshops.
- Training and recruitment of more personnel and deputation of nurses for training to Bangalore, Delhi and Europe.
- Legislation required for admission of voluntary patients and efforts to encourage voluntary admissions.

### **The current hospital**

In 1980, the Mental Hospital under the Directorate of Health Services and the Department of Psychiatry of the Goa Medical College were amalgamated into a single institute, The Institute of Psychiatry and Human Behaviour.

It is a small mental institute with 278 bedded capacity. It caters for a 15 Lakh population in an around Goa. However, there are sometimes admissions from the neighboring States of Maharashtra and Karnataka. This is a hospital in transition, as a new psychiatric institute is under construction at Bambolim.

### **Hospital Infrastructure**

The institute consists of 7 closed wards, 2 open wards, 2 private wards. A high wall encloses the closed wards and criminal wards. It is 3 kms from the Goa Medical College and is situated in a residential area at Panaji. Paying wards have attached toilets. The bed occupancy at the time of report submission was 278 : 142 males, 120 females, 16 criminal in-patients.

### **Administration**

Administration of the hospital is by the Director who is also the Professor of Psychiatry, a Deputy Director (of administration) overlooking the clerical staff, stores and account section. The Medical Superintendent is the overall in-charge.

### **Staffing pattern**

There are 6 psychiatrists, 2 clinical psychologists, 3 psychiatric social workers, 2 trained psychiatric nurses, 68 general nurses and 92 ward attendants, in addition to other supportive and laboratory staff, totaling 221. There are only a few



vacancies. For input from other specialties, the institute liases with the Goa Medical College.

The staffing is perceived as adequate. Only resident doctors live on the campus. The medical staff are available between 9 am and 5 pm. Consultants liaise to provide psychiatric services at the Goa Medical College.

### **Admission and discharges**

Admissions and discharges are undertaken as per the Mental Health Act 1987. Rights of voluntary patients are communicated.

The number of in-patient admissions has declined from 2468 in 1992 to 1900 in 1996. Majority of the admissions are voluntary. Annual death rate is between 5-10, and annual escapes between 6-10 patients. With regard to chronicity, there are only 19 patients who have remained in hospital for more than 2 years of whom 7 have been in the hospital for more than 15 years.

Average duration of stay is 21 days. About 40% of patients are readmitted. Relapse is commonest cause for readmission. Discharge problems mainly occur when relatives are not available, or unwilling to take the patient home. The psychiatric social worker, magistracy, local administration and police are used to trace families.

Patient grievances can be addressed to the Director or Medical Superintendent.

### **Finances**

The budgetary allocation is perceived as adequate, with an increase of planned budget from 20.95 lakhs in 1991-92 to 78.06 lakhs in 1995-96, and non-plan budget from 135.10 lakhs to 202.06 lakhs across 5 years. Sixty percent of total expenditure is spent on salaries, 9% is spent on drugs and approximately 4% on diet. The hospital has not received any donations in cash, but has received material for patients' entertainment. Charges for paying patients (annual income greater than Rs. 50,000) are as per the Government of Goa rules for all Government Medical College services. Much of the funds received recently are for the construction of the new facility at Bambolim.

### **SERVICES**

#### **Casualty and emergency service**

This hospital is unique in that it offers general emergency care to encourage more people to utilize the service. There is no short stay ward. Ambulance facility is present. Basic bio-chemical and pathological tests, psychological testing and EEG facilities are available. Physical emergencies are referred to the Goa Medical College at Bambolim.



## **Outpatient service**

An active outpatient facility is present, and about 100 cases are seen daily. Unit wise posting of doctors is done. There is private space for interviewing patients and sufficient time is spent with patients.

There are satisfactory seating arrangements in the waiting hall. Free drugs are provided to all patients for 1 month. A wide range of anti-psychotic, anti-depressant and anti-convulsant drugs are available. A registration fee of Rs. 5/- is charged.

## **Inpatient service**

All patients have mattresses, and pillows, and 3 sets of uniforms. Each patient has a separate blanket and towel. Patients are allowed to wear their own clothes, and when not available, are provided colorful uniforms in 4 sets per patient. Washing is done at the laundry of the Goa Medical College.

There is 1 toilet for every 15 patients, and 1 fan for every 5 patients. Record maintenance is adequate. Shaving facilities for males are provided weekly and hair-cut once in 2-3 weeks. No routine shaving of the head is done. Anti lice / bug measures are adopted quarterly. Almost all the patients receive free treatment. Sixteen seclusion wards with iron gates are present and used regularly. Criminal patients are in single cells and completely isolated. There are regular visiting hours.

## **Dietary and pantry facility**

Expenditure on diet is approximately Rs. 15/- per person, providing about 1800 calories / day. Diet is served thrice ( at 7am, 1pm and 7pm). A steward is in-charge of the food preparation. Drinking water is provided in aluminum mugs.

Food is transported in closed containers. There is no separate dining facility. Cooking is done by gas. The hospital recognizes the need for increasing the quantity of food per patient, and the need of a separate dietician to ensure consistency in quality.

## **Investigation and treatment facilities**

Basic investigations including lithium estimation facilities are available. Separate laboratory staff are available.

## **Records**

Separate records for each patient are maintained by the Medical Records Department, which has 16 staff. However, there is no independent office for the records.



## **Patients rights**

Patients are allowed to write to their families. Families are encouraged to visit. Canteen facilities are available, predominantly for paying ward patients. While newspapers are provided, there are no library facilities. There are some recreational facilities for patients. Board of management meets once a month.

## **Rehabilitation services**

Occupational therapy sections include embroidery, craft, candle making and gardening. However, the rehabilitation centre can cater to about 30 patients, and about 25 patients were utilizing these services at the time of evaluation. There are no separate wards for patients undergoing rehabilitation. There is no day care or half way homes. Incentives are paid. There is little liaison with voluntary agencies and non-governmental organizations.

## **Community programmes**

The institute has an active community programme with a rural, geriatric and prison extension service. While there is a structured training programme for psychiatric trainees there are no formal training programmes for other mental health professionals.

There have been no attempts so far to initiate the District Mental Health Programme.

## **Staff issues**

While the medical staff meet on a monthly basis, there is no regular meeting of the non-medical staff. The staff morale, especially among the non-psychiatric mental health professionals is low, one reason being the lack of promotional avenues. Discrepancies between designation and qualification are also present; for ex., a qualified mental health professional (clinical psychologist) has a designation lower than a person with less qualifications.

## **Court representation and orders**

The first public interest litigation concerned the use of direct ECT. This was filed, on behalf of an inpatient who had been administered direct ECT, in the High Court of Bombay at Panaji (Civil Writ Petition No : 257/98), Collasso versus State of Goa and Others. The issues for determination included:

- Whether administration of ECT without anaesthesia was barbaric and inhuman and hence in violation of Article 21 of the Constitution.



- Whether administering ECT without anaesthesia was in violation of Section 81, Chapter VIII of the Mental Health Act which provides that no mentally ill person shall be subjected during treatment to any indignity (physical or mental) or cruelty.

The Court in its judgement while disposing the petition directed that it was preferable to use modified ECT's under proper supervision unless otherwise indicated.

### **The new facility at Bambolim**

The new facility at Bambolim, on the Panaji Vasco highway is close to the Goa Medical College. The site is huge and spacious. The mental health professionals have been involved in planning of the construction. The new hospital has multiple units connected by long corridors. The kitchen is roomy and well planned. A part of the social service complex building presently abandoned by the Social Service Department will be converted to a ward for chronic patients. A separate outpatient building with comprehensive facilities is under construction.

The two main concerns for patients' safety are:

- the proximity to the busy highway,
- the presence of an adjoining quarry.

Some arrangements need to be made for patients and family members from the main road to the out-patient premises as the distance may be too much for many to walk. The new building promises to realize many more of the recommendations earlier made by Dr. Govinda Swamy.

### **Summary**

While the Institute of Psychiatry and Human Behaviour, Goa, is an example of one of the better psychiatric hospitals in the country, and has incorporated many modifications for improvement there are some areas that still deserve attention.

### **SUGGETIONS**

- Special facilities for substance use and for children with psychiatric problems should be introduced
- Services for the criminal mentally ill are unsatisfactory and should be improved.
- More extensive rehabilitation services, catering to more of the recovered patients should be evolved. The vast area in the new premises will certainly facilitate this.



- Sensitization regarding the rights of the mentally ill should be arranged for all categories of staff.
- Better liaison with voluntary agencies / NGOs.
- Regular meetings of different groups of mental health professionals with administration to discuss patient issues, improvements of facilities, as well as staff grievances. This will certainly help in improving staff morale.



# CHAPTER-20

## G U J A R A T

### INTRODUCTION

Gujarat became an independent state on the 1<sup>st</sup> of May 1960 under the Bombay Reorganization Act. It covers an area of 196,024 sq. km and has a population of about 41 million. The density of population is 210 persons per sq.km. The sex ratio is 936 females per 1000 males and about 35% of the population live in urban areas. The literacy rate is 61% being significantly higher in males (73%) as compared to females (49%).

Gujarat occupies the northern extremity of the western seaboard of India. It is divided into 3 geographical regions: 1) the Peninsula, traditionally known as Saurashtra, comprising of hilly tract and low mountains, 2) the Kutch region on the northeast which is barren and rocky and contains the famous Rann (desert) of Kutch. Although relatively sparsely populated it is of strategic importance as it is situated close to the India-Pakistan border and 3) the Mainland extending from the Rann of Kutch and the Aravalli hills to the river Daman-ganga.

The state is divided into 19 districts with the capital at Gandhinagar. Gujarat has 4 mental hospitals, 2 located in the western region and 2 in the east. While the hospitals in Ahmedabad and Vadodara serve the mainland region, the hospital in Jamnagar serves the Saurashtra area and the politically sensitive northwestern region has a hospital in Bhuj. In addition, there are departments of psychiatry in 6 medical colleges situated in Ahmedabad, Vadodara, Surat, Jamnagar, Rajkot and Bhavnagar. There are posts of honorary psychiatrists in 10 Civil Hospitals in Palanpur, Mehsana, Himatnagar, Godhra, Bharuch, Navsari, Amreli, Bhuj, Porbandar, Junagadh, Rajkot and Bhavnagar. However, many of these posts are not functional.

### HOSPITAL FOR MENTAL HEALTH, AHMEDABAD

#### Background

The British Government established the Hospital for Mental Health in Ahmedabad with 50 beds in 1863 as a mental asylum. By 1872 the number of beds increased to 180. Presently the bed strength is 317 with 61 beds for female patients. This includes 10 beds for the Union territories of Daman and Diu. Dr. D.D. Vanaiya was the first Indian superintendent and served from 1942 to 1946. The present superintendent, Dr. R.H.Bakre is a senior psychiatrist.



The hospital is centrally located in a commercial area and is close to the bus stand and railway station. The approach road is very unobtrusive, bordered by shops on either side. The government has acquired some of the land of the hospital, near the entrance, and built a guesthouse for VIPs. Hence, the approach road is usually well maintained.

### **Hospital infrastructure**

The main hospital is built on the lines of a prison with single cells. Many parts of the building are no longer habitable and have been closed down. Plans for a new hospital have been sanctioned and, once the new hospital is in place, the old structure will be demolished. There are no special or paying wards. Charges are collected only when specifically ordered by the court. All wards are closed and there is no separate building for criminal patients. Patients are housed in single or 2-bedded rooms and there are a few additional structures having 4 to 6 patients.

About 50% of the patients have cots with adequate bedding. Lighting and ventilation is poor. Installation of fans and tubelights is in progress in some of the wards. However, it appears that the current living arrangements do not protect the patients from the vagaries of the weather, which in Gujarat, are fairly extreme. The toilet facilities are inadequate, with minimal arrangements for female patients and male patients having to use open drains for urination and defecation. While solar heating has been installed for hot water, the bathing arrangements on the male side do not provide for privacy.

### **Staffing pattern**

The medical superintendent is the overall in charge and the only psychiatrist. He is assisted by an administrative officer and the Resident Medical Officer (RMO) on the clinical side. There are 5 medical officers, 1 clinical psychologist and 2 psychiatric social workers. There are 35 nurses in addition to the matron, none of whom are trained in psychiatric nursing. There are 5 technical staff, 13 administrative staff and about 120 group D staff. All posts are full time with pay scales fixed by the state government. Most of the nursing and group D staff stay in the campus. The doctors working hours are six hours a day and are available on call, the rest work for eight hours a day. An anesthetist and general physician come as visiting consultants. Two psychiatrists come from the general hospital psychiatric unit (B.G. Medical College) to help run the outpatient services. Residents in Psychiatry doing their MD are posted for three months.

Overall, the staff position is inadequate in terms of professionally trained staff. There is a need to increase the number of posts for psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses. Some of the nursing staff



are motivated for undergoing formal training in psychiatric nursing, provided their service is protected and the government deputes them.

## **Admission and discharge**

All admissions are governed by the Mental Health Act, 1987 with the admitting authority being the psychiatrist / Medical Superintendent and the judiciary. However, voluntary admissions are very low forming barely 4% of the total admissions. Most of the admissions (47%) take place under the 'special circumstances' clause and an equal number (44%) are admitted through the court. Undertrial and criminal prisoners form another 5% of the admissions.

The current occupancy is about 75% (N=254). Approximately 50% of the patients (N=127) are long stay, having been in the hospital for more than 5 years. The average duration of stay for the remaining is about 4 months (127). There are about 10 deaths (3%) in the hospital per year, but no suicides, homicides or escapes. Decertification is done by the hospital authorities and patients discharged with relatives. Occasionally patients may be sent home with hospital escort and rarely (in the case of males) sent home alone. Discharge problems are mainly due to the family being unable to support the patient due to the financial burden and because there are no psychiatric facilities close to their homes in case of an emergency.

Relapse of illness or exacerbation of symptoms due to discontinuation of medication is the most common reason for re-admission. Patients are informed of their rights and, through the staff, can address their grievances to the board of visitors.

## **Finance**

Although there has been an increase in the plan and non-plan budget over the years this increase has not been significant. The current plan budget is about 67 lakhs and the non-plan about 127 lakhs. The bulk of the expenditure (73%) is on salaries, and the remaining on food (13%), medication (3%) maintenance and miscellaneous (9%) and linen (2%). The budget allocation is perceived as inadequate and barely sufficient to maintain the existing arrangements. Donations have been received in cash and in kind in the form of medicines, steel utensils, blankets and other linen, water cooler, television sets, fans etc. Individual donors sponsor a meal in the hospital as often as 15 to 20 days in a month.

## **SERVICES**

### **Casualty and emergency service**

The hospital does not have casualty or emergency services. There is no short stay ward. Patients are directly admitted to the wards. There is no ambulance facil-



ity. When required for the in-patients the ambulance is summoned from the civil hospital or the fire brigade.

### **Outpatient service**

The outpatient service is run every day from 8.30 am to 1.30 PM. There is a waiting hall which can seat about 10 people at a time, 2 rooms for interviewing and examining the patient, and a separate room to sedate excited patients. Except for 2 visiting psychiatrists from the general hospital, who come twice a week, there are no separate personnel to run these services. This puts a considerable burden on the existing staff. About 60 to 65 patients are seen per day. Occasionally, excited patients are brought tied up. The average waiting time is 30 to 40 minutes and about 5 to 10 minutes per follow-up. Separate records are maintained in the outpatient itself and managed by one of the clerical staff. There are no charges for the outpatient services and all patients receive free medication for a period of 1 month. The supply of medication is good including newer drugs. However, due to shortage of staff no psychosocial intervention is possible. Some information regarding mental illness is painted on the wall of the waiting room but inputs for mental health education are generally poor. The present arrangements are insufficient and a separate building is required with adequate staff.

### **Inpatient service**

Overall, the in-patient facilities are inadequate because of the current living arrangements. The female wards are marginally better than the male wards. There are no separate wards for acute and chronic patients or any kind of intensive care (ICU) facility. Wards are cleaned daily and linen is changed at least once a week. Patients can bathe daily and provided with fresh clothes twice a week. Although they are permitted to wear their own clothing, most of the patients are in hospital uniform. Laundry is hand washed by a dhobi on the premises. Toilet, lighting and other furniture are inadequate. There are no personal lockers available. Services of a barber are provided. Routine head shaving is not done. Male patients have a weekly shave and a monthly hair cut. Anti lice/bug measures are adopted twice a year or when required. Chemical repellents are used for mosquitoes. There is no room for the duty doctor in the ward and emergency facilities are grossly inadequate.

The kitchen is housed in a poorly ventilated building. However, storage of provisions is good and the quality of raw materials purchased is monitored. Cooking gas facility is available and the food cooked is nutritious, tasty and in adequate quantity. Three meals plus tea amounting to approx. 2500 calories per day at the



rate of RS 20/- are served. The cooked food is checked daily by one of the staff. The food is carried from the kitchen in covered steel containers. Meals are served in steel plates and patients sit in the verandah on the floor. Drinking water is available in each ward. Patients are involved in different stages from helping in the kitchen, transporting and serving. Almost 15 to 20 days in a month, individual donors sponsor lunch with a fruit or sweet. For these meals, the donors provide the provisions and the food is cooked in the hospital to ensure safety and quality. However, the donors are present when the food is being served. Many of the donors do this on a regular, annual basis on a predetermined date, usually in memory of a relative.

Basic laboratory facilities such as routine blood and urine examination are carried out. EEG recording facility is available. The clinical psychologist does psychological testing and home visits and admission-discharge problems are attended to by the psychiatric social worker. Pharmacotherapy is adequate and modified ECT's are administered. Violent patients are controlled primarily through medication. Patients are not put in isolation on a routine basis.

Library facility for patients with newspapers and magazines is present and recreational activities through music, dance and games are organized regularly. Occupational therapy is carried out with activities such as charkha, carpentry, weaving and candlemaking on the male side and embroidery, rug and bag making on the female side. Other individual and family based interventions are minimal. A separate case file is opened on admission and these records are maintained at least for 10 years. Confidentiality of records is adequate.

Although family members are permitted to visit the patients this does not happen on a regular basis. There are no open wards or facility for a family member to stay with the patient or on the campus for a few days. There is no telephone or canteen facility for patients/family. Interviews with family members indicated that they were satisfied with the services provided and with the patients' treatment. However, their level of knowledge and understanding of the nature of illness and treatment was low. Patients and families tended to become dependent on the hospital. There is a need to increase the level of contact with the family and provide psychoeducation on a routine basis.

### **Community service**

Several NGO's such as the Gujarat Sarvar Mandal, the Mahila Mandal, the Lion's club, Mental Health Society and the Sad-karya Seva Samaj are actively involved in the activities of the hospital especially the recreational and cultural programs. The Mahila Mandal has offered to start a day care center in collaboration with the hospital. A community district mental health program at Sabarkantha had to be discontinued because of lack of funds.



## Legal aspects

Board of visitors has been constituted according to the Mental Health Act 1987. A civil court judge is a member of the board. A long-standing tradition here has been the excellent liaison between the judiciary and the hospital. There has been no public interest litigation against the hospital. This is largely due to the efforts of the medical superintendent and his team.

Despite severe constraints both of infrastructure and staff, the medical superintendent has tried to improve the services provided. The government has now committed funds for the construction of a new building. There are also plans to make this hospital a teaching and research centre for the state.

## Suggestions

- Construction of the new hospital building must be started without further delay.
- In the interim period some basic toilet facility has to be provided for the male patients.
- In the new building there should be open wards where a relative can stay with the
- patient, family wards wherein the family as a whole unit can be given specialized
- inputs. There should be special wards on payment basis and an Intensive Care Unit
- for physically ill patients and emergencies.
- Criminal patients should be kept separately or treated in the jail itself by a visiting
- psychiatrist.
- Patients to be provided with individual lockers and encouraged to wear personal
- clothing.
- Staff pattern has to be improved considerably. Posts of psychiatrists, clinical
- psychologists, psychiatric social workers and psychiatric nurses have to be created.
- Greater attention needs to be paid to psychosocial intervention so as to reduce the



- duration of hospital stay and the disability of the patients.
- Mental health education needs to be taken up on a war footing and families need to be involved as partners in care.
- The response of the community and NGO's has been positive and this needs to be
- Channeled so as to facilitate early rehabilitation of the patients.
- Rehabilitation facility has to be improved.

## **HOSPITAL FOR MENTAL HEALTH, VADODARA**

### **Background**

The Gaekwad family established the Hospital for Mental Health in Vadodara in 1898. It was handed over to the Government of Bombay after independence in 1948. When the government of Gujarat took over in 1960 the number of beds was 155. In 1991, the bed strength was increased to 300, which includes 100 beds for female patients. The present superintendent, Dr. B.H.Buch is a senior psychiatrist.

The hospital is centrally located and about 3 km from the bus and train services. The Civil hospital is also close by.

### **Infrastructure**

High walls surround the hospital complex. There are several buildings spread out within this complex. The administrative offices and the OPD are in one block. Male and female patients are housed in two separate blocks. There are no special wards and no separate facilities for criminal patients. Patients are housed in rooms with 4 to 6 beds each or single rooms (old cells) with 1 to 2 patients in each. However, the size of the rooms is small and some are overcrowded. Six rooms in a single row have been converted into open ward facilities with a family member being able to stay with the patient. Majority of the patients are treated free of cost and the rest (2%) have to pay for the treatment depending on the order of the court.

The basic structure is still in good condition. However, in many places the tiles on the floors and walls have been badly damaged and the walls need to be replastered. Construction that has taken place around the hospital complex has affected the drainage system within the hospital. The toilets are not in good condition and there is a problem of running water. During the day, lighting and ventilation are adequate. Electrical lighting is insufficient and this is being upgraded. The superintendent has come up with an innovative idea so that both the corridors and rooms can be lit simultaneously and at the same time prevent any tampering with the fixtures. How-



ever, the quantum of light generated will be insufficient for activities such as reading or writing. There are no fans in the rooms, but air coolers for both male and female side are being installed.

### **Staffing pattern**

The superintendent is the overall in charge and the only psychiatrist. An additional post of psychiatrist is vacant. The superintendent is assisted by an administrative officer and the Resident Medical Officer (RMO) on the clinical side. There are 7 medical officers, 1 social worker and 30 general nurses. There are no clinical psychologists, psychiatric social workers or psychiatric nurses. Other staff comprise of one laboratory technician, 9 administrative staff and 52 group D staff. The current staffing position is inadequate.

All posts are full time with pay scales fixed by the State Government. The medical superintendent stays in the campus. The doctors work a 6-hour day and are available on call while the other staff have an 8-hour duty. There are 2 part-time posts of dentist and neuro-physician which are currently vacant. Students doing their masters in social work are posted for block placement.

### **Admission and discharge**

All admissions are governed by the Mental Health Act, 1987 with the admitting authority being the psychiatrist / Medical Superintendent and the judiciary. The number of voluntary admissions has been increasing, but still forms just 15% of the total admissions. Admissions under 'special circumstances' is next (23%), and the majority of admissions is still being done through court order (63%). The current occupancy is 100%, however, one-third of the patients may be on 'leave of absence'. About 50%(N=200) of the patients are long stay having been in the hospital for more than 5 years. The average duration of stay is about 4 months. There are about 6 deaths per year (2%) and there has been one escape in the past few years. There have been no instances of suicide or homicide in the hospital. Decertification is done by the board of visitors and the hospital authorities and patients sent home with their relatives or with hospital escort. Discharge problems are mainly due to the family being reluctant to accept the patient and having difficulty in bringing the patient for follow-up. Relapse of illness due to drug default forms about 25-30% of the re-admission. The patients are informed of their rights and usually address their grievances through the social worker.

### **Finance**

There has not been a significant increase in the plan and non-plan budget in the past few years. The current plan budget is about 19 lakhs and the non-plan budget is



about 85 lakhs. The bulk of the expenditure is on salaries (82%), and the remaining on food (9%), medication (3%), maintainence and miscellaneous (3%) and linen (3%). The budget allocation is adequate for maintaining status quo. Donations are utilized to meet certain service needs like investigations such as CT scan or psychological testing and there have been donations in kind such as electrical fittings, water cooler etc. Twice a week a local trust called the Jalaram Trust sponsors food for the patient. They also provide food every day for the relatives in the open ward.

## **SERVICES**

### **Casualty and emergency service**

There is no casualty or emergency service. There is no short stay ward and patients are admitted directly to the wards. There is no ambulance facility. Patients are shifted to the general hospital by autorickshaw.

### **Outpatient service**

Outpatient services are run twice a week on Tuesdays and Fridays from 9 to 1pm. There is a waiting hall which is also a place where relatives can meet and spend some time with the patient. There are 4 interview rooms. There is no separate staff for running these services and the case records are maintained by the social worker. The number of persons attending the OPD has been steadily increasing and has doubled in the last ten years. The average number currently is about 16. The average waiting period is about 30 to 40 minutes and the time spent is about 5 to 10 minutes per follow-up. There are no charges for the services and patients are given free drugs for a month. The supply of medication is adequate with newer drugs also available. However, except for minimal counseling provided by the social worker, there is no psychosocial intervention. Educational information regarding mental illness and health is not available. If the services are to expand and improve a new building with adequate, trained staff is required.

### **Inpatient service**

The living arrangements are barely adequate. The structure needs some urgent repairs and a facelift. The toilets have to be improved with running water and adequate sanitation. There are no separate wards for observing the acutely ill or ICU arrangements for the physically ill. There are 10 single cells available, but used infrequently. The duty doctor's room has basic facilities.

Wards are cleaned daily and linen changed once a week. Patients have a bath everyday and provided a fresh set of clothes twice a week. They are also permitted to wear their personal clothing. On the female side, the superintendent has provided



colored saris instead of the uniform. Laundry has been given on contract and the arrangement is satisfactory. About 60-65% of the patients sleep on cots. There are no individual lockers for personal belongings or any other furniture. Services of a barber are available. Head shaving is not done routinely. On the male side, hair cutting is done once a month and shaving once a week. Delousing is done when needed. Antihelmenthic and anti-malarial treatments are given routinely.

The kitchen is housed in a separate building with adequate lighting and ventilation. However, storage facilities are not adequate. Food is prepared on gas in steel vessels. One stove has been innovatively modified to prepare soft chapathies on a large scale. Attempts to reduce pilferage have resulted in better quality and quantity of food provided. For e.g. butter supplied with bread in the morning would be routinely pilfered. It is now converted into ghee and put on the chapathies. The 3 meals plus tea amounts to approximately 2500 calories per day at the rate of about Rs.15 for each individual. The staff checks the cooked food. Twice a week food is sponsored by a local voluntary organization, the Jalaram Trust.

The food is transported on a cart in closed containers to the dining areas. There are separate dining halls for men and women. Meals are served in plates and distributed by the attenders. Seating arrangement is on the floor. Filtered and cooled drinking water is available in the wards. Special diet including milk, eggs and fruits is given to about 10-15% of the patients.

Except routine blood and urine examination there is no laboratory facility. ECT's are not given due to non-availability of an anesthetist and patients' requiring the same are sent to the general hospital. Pharmacotherapy is adequate. Violent and excited patients are controlled with medication and/ or seclusion in single room. General physical health of the patients is good. This is because the medical officers have an effective system of monitoring the physical status and routine notes in the in-patient records are entered. The medical officers maintain a chart which ensures that each patient is examined in detail every 15 days.

Psychological testing and use of psychotherapy and behavior therapy is absent as there is no clinical psychologist. When psychological testing is required, it is referred to an outside agency and either the relatives bear the charges or it is paid through the donations. The medical superintendent felt that this was an essential service especially for diagnostic problems and medico-legal cases. Other individual and family based interventions are minimal. The students of social work posted spend time interacting with the patients, writing letters for them etc and provide some social stimulation. Recreational facilities are present in both wards mainly music, TV and a few games. There is a separate hall for conducting social and cultural programs especially during festivals. Minimal occupational therapy services are present with embroidery, tailoring and card making on the female side and



rug weaving and carpentry for male patients. Although instructors are present, the absence of a trained occupational therapist is felt. Individual case records are opened on admission and confidentiality of records is adequate. However, there is no trained staff to handle the records.

A progressive step is the conversion of six single rooms into an open ward where the relative can stay with the patient. Toilet and bathing arrangements are detached. Relatives are mainly from the weaker sections of society and appear satisfied with the services provided. While the patients get free food from the hospital, for the relatives, food passes have been arranged from the local Jalaram Trust. This service needs to be expanded and strengthened and the relatives need to be actively involved in the therapeutic process. There is no phone or canteen facility on the campus.

### **Community service**

Several NGO's and individual donors have come forward in a big way to improve the facilities, such as provision for water coolers and air coolers etc. In collaboration with the faculty of social work, an orientation and sensitization program for school teachers regarding the mental health problems of children is being carried out.

### **Legal Aspects**

The board of visitors has been constituted as per the Mental Health Act 1987. The members include a district session judge, the superintendent of police (in charge of prison) and a professor from the department of social work. No public interest litigation has been filed against this hospital. This is one of the few hospitals where the medical superintendent is very aware of the rights of the mentally ill and conversant with the Mental Health Act 1987. Despite financial constraints and poor infrastructure, attempts are made to improve the existing facilities and provide better services. Community participation and donations are actively mobilized for this purpose. The medical superintendent takes frequent rounds of the hospital and is particular about the quality of care. Although he has the support and cooperation of the medical and nursing staff, the group D staff feel that he is strict and demanding.

### **SUGGESTIONS**

- Infrastructure to be upgraded especially for improving outpatient services, wards, toilets and providing an intensive care (ICU) facility and rooms for the staff and duty doctor.
- Arrangements to administer ECT in the hospital and the services of an anesthetist either part-time or as a visiting consultant.



- A positive step has been the starting of open wards and this needs to be substantially strengthened.
- Special rooms on payment basis should be made available.
- Staff pattern has to be improved and psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses are to be appointed.
- Rehabilitation services to be improved and daycare/sheltered workshops can be started within the hospital premises.
- The medical superintendent is dynamic with innovative ideas and leadership qualities. He is aware of the newer developments in the field and sensitive to the professional inputs provided by other members in a multidisciplinary team. Greater support needs to be provided for this centre for e.g. in terms of computer and library facilities etc so that training and research initiatives can be undertaken.

## **HOSPITAL FOR MENTAL HEALTH, JAMNAGAR**

### **Background**

The Hospital for Mental Health in Jamnagar, was established in 1959. The old building was declared unfit for habitation and a new hospital was constructed on the lines of a hospital in Switzerland. It was occupied in 1984. It is a 50 bedded hospital with 10 beds for females. It is located in a residential area in the centre of the city in close proximity to the general hospital.

The hospital has been built with a provision for the family member to stay with the patient with toilet facility and cooking arrangements. Adequate open space has been provided for activities like gardening and outdoor games. However, the infrastructure is grossly under utilized as this hospital has no psychiatrist. This has resulted in almost half the building and compound being allotted to a dental hospital and college. As a consequence, the patients in the mental hospital are kept locked within the building.

The hospital continues to function without the full time services of a psychiatrist, the current medical superintendent being an anesthetist, Dr. Changrela. The community perceives the patients as violent and dangerous and there is pressure from the neighborhood that the hospital should be relocated.

### **Infrastructure**

The hospital was built as a mental health facility. Although the basic structure is still in good condition, maintenance has been inadequate. Many portions are still not being utilized and many of the electrical fittings, fans etc are rusted from disuse.



All wards are closed and there are 3 cells for male patients and 1 for female. There are no special wards. Criminal patients are kept in the cells with police escort.

There are adequate number of cots and bedding per patient. However, a number of cots are broken and neither repaired nor condemned. Lighting and ventilation is adequate. Toilets with adequate privacy are present but the general maintenance needs to be improved. There is no continuous supply of water. Hot water for bathing is provided by means of an electrical geyser.

### **Staff pattern**

Staff position is grossly inadequate. There are 2 medical officers and 3 nurses. Mental health professionals are conspicuously absent. There is no psychiatrist, clinical psychologist, psychiatric social worker or psychiatric nurse. Minimum services are provided with the help of 2 psychiatrists from the civil hospital. The group D staff position is adequate. All posts are full time with government pay scales. The doctors work a 6-hour day and the rest an 8-hour day.

There is quite a high degree of burnout. Group D staff are at the receiving end often having to deal with violent and uncontrollable patients without adequate support from the medical staff. This is particularly a problem in the evenings and nights when no medical personnel are available. The nurses expressed interest in undergoing specialized training in psychiatric nursing. Nurses and attenders expressed a need for better facilities for the staff in terms of changing rooms and toilets.

### **Admission and discharge**

All admissions are through the judiciary by court order. The occupancy is about 70% (N=35). There are not many chronic patients. The average duration of stay is about 5 and ½ months (167 days). On the average, there are 4 deaths (11%) per year, 4 to 5 escapes and there has been one instance of homicide. Decertification is done by hospital authorities and patients discharged with relatives or sent with police escort. Family members are not very willing to take patients on discharge. Ten to fifteen percent of the cases get readmitted having relapsed due to discontinuing medication. The awareness of rights of the patients even amongst the staff is low and patients are not informed of their rights.

### **Finance**

The budget is about 19 lakhs. The bulk of the expenditure is on salaries (74%) and the remaining on food (13%), drugs (4%) maintenance and miscellaneous (7%) and linen (2%). The budget allocation is perceived as being adequate for the existing services. Contributions from NGO's have been in the form of ECT machine, water cooler, television and radio etc.



## **SERVICES**

### **Casualty and emergency service**

The hospital does not have casualty and emergency services. There is no short stay ward. Patients are admitted directly to the wards. There is no ambulance. Patients are sent to the civil hospital whenever required.

### **Outpatient service**

An outpatient service is run twice a week with the help of psychiatrists from the civil hospital. On an average, 2 to 3 new cases are seen per week and about 10 to 15 old cases. There is a waiting hall, but no separate rooms for interviewing the patients. There are no charges levied and all patients are given free medication for one month. Stock of drugs is adequate. Psychoeducation and even minimal counseling is absent.

### **Inpatient service**

Overall, the in-patient services are inadequate because of lack of professionally trained staff. Wards are cleaned daily and linen changed at least once a week. Patients are permitted to bathe daily and provided a dress change once a week. All patients wear the hospital uniform. Patients, especially on the female side, were not happy with the type of clothing and the frequency of dress change. Many patients complained that toiletries especially soap was insufficient. Nursing and group D staff reported that the laundry service was not adequate and this resulted in persistent body lice and skin infections. Head shaving is done routinely for male patients. Adequate delousing procedures are not adopted and many female patients complained of lice in the head. No lockers are provided for personal belongings. Toilets do not have running water.

There is no room for the duty doctor. There is a separate case file for each patient, but clinical notes regarding the condition of the patient are not entered regularly. Violent and excited patients are kept in isolation cells. There have been complaints from residents in the neighborhood that patients are heard shouting and fighting at night. Staff showed mangled steel plates and broken cots as evidence of this. Arrangements for such situations are highly unsatisfactory with only one male attender on duty at night. Attenders complained of having been assaulted by patients.

There is a separate building for the kitchen with adequate space for storage of provisions. The food is cooked on gas and checked by the superintendent or other staff. Three meals plus tea amounting to 2500 calories at the rate of RS. 15/- per head are provided. Food is carried in closed containers to the wards. Meals are



served in plates (all are not steel) and patients are seated on the floor. Low benches and tables suited to the local culture are present but are not being utilized. There is a water cooler donated to the hospital, but drinking water is not available in the wards and patients have to use the water from the tap.

No laboratory facilities are available. All investigations are carried out at the local civil hospital. A mortuary chamber, which can hold 2 bodies at a time, is present. As there is no clinical psychologist, psychological testing is not carried out. Modified ECT's are administered as the medical superintendent is an anesthetist. However, frequency is often not maintained as he is sent for camps and other duties. Pharmacotherapy needs to be improved mainly in terms of regular monitoring for effective dosage.

Due to lack of professional staff no psychosocial intervention is carried out. Minimal recreational activities are present in the form of television, radio and indoor games, but not accessible to most of the patients. Recovered patients are housed in a separate ward, but are not engaged in any activity. A few of these patients complained of feeling bored. No facility for occupational therapy is present. Attenders mentioned that in the old premises, patients used to be involved in horticulture activities and the produce would be sold in the market. Patients used to enjoy and benefit from the outing. Such activities need to be re-introduced at the earliest.

There are no open wards where a family member can stay with the patient. There is no telephone or canteen facility. In general, contact with family members is very low.

### **Community service**

Except for the 2 psychiatrists who come from the civil hospital, there is no liaison with any professional organization. Two students from the local Ayurvedic college come on their own initiative and spend some time observing the patients. There is no community mental health program. Although there have been individual donors, not much initiative has been shown in involving the local NGO's, corporate sector or citizens in public life. In fact, a large private corporation with a major presence in Jamnagar is willing to be involved especially in rehabilitation work. Social and cultural activities are not organized in the hospital.

### **Legal aspects**

Board of visitors has been constituted and is supposed to meet every three months. It has the district sessions judge, the superintendent of police (prisons) and social workers on the board. Currently, the board is not meeting regularly. Since all admissions are through the court they have to be decertified for discharge, which is done by the psychiatrists from the civil hospital. There is no public interest litigation



against the hospital. Overall better the awareness of the rights of the mentally ill amongst staff and patients needs to improve.

## **SUGGESTIONS**

- A psychiatrist should be immediately appointed as the medical superintendent. He should preferably have some experience in administration or sent to the hospitals at Ahmedabad or Vadodara for a short training. Staff position has to be improved immediately, to change the type of care from custodial to therapeutic.
- Staff needs to be sensitized about the rights of the mentally ill.
- Involuntary admissions need to be kept to the minimal.
- Open wards to be started and family members to be educated and involved as partners in care.
- Running water in toilets and improvement in clothing and linen.
- Involvement of voluntary organizations especially for starting rehabilitation services.

## **HOSPITAL FOR MENTAL HEALTH, BHUJ**

### **Background**

The Hospital for Mental Health in Bhuj was established in 1957 with a capacity of 16 beds. It is centrally located and close to the bus and train services and the general hospital. The medical superintendent is a young psychiatrist, Dr. Sanjeev Gupta. This is the only psychiatric facility in the area and the demand on the services has been steadily increasing. An additional feature of this hospital is that it is located in a geographically sensitive area. Persons found near the Indo-Pakistan border are picked up for interrogation by the police and sent to the mental hospital for examination of mental status.

### **Infrastructure**

The condition of the building is fairly good and built to suit the local climatic conditions. All wards are closed and there is no separate facility for criminal patients. There are no special wards. Single cells are present. Ward maintenance is adequate. Basic facilities in terms of toilets, lighting and fans are adequate. Each patient has a cot with bedding. No personal lockers are provided.

### **Staff pattern**

The medical superintendent is a psychiatrist and the overall in charge. He has



no other professional assistance except for the services of one nurse. Administrative and group D staff are adequate in number. With the demand for services on the rise it is imperative that the staff position be improved in order to maintain the quality of care.

## **Admission and discharge**

All admissions are governed by the Mental Health Act, 1987 with the admissions being made by the psychiatrist. Majority of the admissions are on voluntary basis. The current occupancy is more than 100% (N=21) because the hospital is becoming popular and well accepted. The need to increase the bed strength of this hospital has been recognized by the health secretariat. There are just 2 chronic patients. Active efforts are made to reduce the duration of stay in the hospital. Patients being brought from far distances are admitted for a few days with their relatives and rapidly brought under control with medication. This has had a positive effect on both the patient and the family. Moreover, it minimizes 'dumping' in the hospital and reduces chronicity. Stay in hospital may, therefore, vary from a few days to one or two months. There is a rapid turnover of patients. On an average, 2 deaths per year are reported; there are no suicides, homicides or escapes. Most of the discharges are with relatives and occasionally with police escort. Relapse of the illness accounts for about 20% of the readmission.

## **Finance**

The plan budget is about 10 lakhs and the non-plan budget about half a lakh. The break up of the expenditure is 74 % for salaries, 11% for diet, 8 % for drugs and 0.7 % for linen and rest 6.3% for maintenance and miscellaneous. The budget is perceived as adequate for the existing services. Donations have been received in kind such as an ECT machine, wall clock and washing machine.

## **SERVICES**

### **Casualty and emergency service**

There is no casualty and emergency service. Patients requiring admission are admitted directly. There is no ambulance facility. Medical emergencies are sent to the general hospital.

### **Outpatient service**

Outpatient service was started in 1993 in a new building constructed for the purpose. It is run daily from 9 a.m. to 1 p.m. and from 4 to 6pm. On an average 25 cases are seen per day. Occasionally patients are brought tied with ropes. There is a small waiting hall and one room for interviewing the patient. Average time spent



with each patient is about 10 to 15 minutes. There are no charges and drugs are given free of cost for one month. Supply of medication is adequate. However, since there is no additional staff, pharmacotherapy is the only treatment administered.

### **Inpatient service**

Overall, the inpatient facilities are adequate because it is a small hospital and easy to maintain. Wards are cleaned daily and linen changed at least twice a week. Patients wear hospital uniform and bathe 2 to 3 times a week with a change of clothes. Basic facilities in terms of toilets, lighting, fans and cots are adequate. No personal lockers are provided. Services of a barber are available and routine shaving of head is done for both male and female patients. Excited patients are brought under control with medication.

Food is prepared on gas under hygienic conditions. Quantity of food is adequate. Drinking water is available in the wards. Food is served in steel plates and patients eat in the verandah. Left over food is served to pigs that live on the campus.

Laboratory facilities are not available and all investigations are done at the general hospital. Psychological testing is not carried out as there is no clinical psychologist. Modified ECT's cannot be administered regularly because of non-availability of the anesthetist. Pharmacotherapy is adequate. However, no formal psychosocial inputs are made. There is no recreational or occupational therapy provided. A separate case file is opened for each patient. There is no trained person to handle the records. Confidentiality of records is not assured.

There are no open wards or family wards. There is a telephone facility but no canteen.

Awareness and knowledge about mental illness is very low. Since there is no other psychiatric facility this centre has also been receiving patients from the middle and upper socioeconomic strata who can afford to pay for the services. So some system of charges and paying wards should also be introduced.

### **Community service**

Local charitable organizations and the Lion's and Rotary are associated with the hospital and participate in the social and cultural programs. There is no formal community based activity.

### **Legal aspects**

The board of visitors has been constituted as per the Mental Health Act 1987. It comprises of the local collector, judicial magistrate, jail superintendent and some prominent citizens. The frequency of meeting is about twice in a year. The superin-



tendent expressed that scheduling of formal meetings has been a problem, but that the board members are accessible and cooperative.

There is no public interest litigation filed against this hospital. It is frequently visited by politicians and other VIP visitors and has benefited from the same. The medical superintendent is young and quite enterprising and has managed to mobilize community support.

## **SUGGESTIONS**

- Staff position needs to be strengthened with adequate number of mental health professionals.
- Anesthetist on part-time basis or as a visiting consultant for proper administration of ECT 's.
- Bed strength can be increased to about 30, as there is a greater demand for service in the region.
- New wards should be open wards with facility for family member to stay with the patient.
- Special wards and single rooms with attached toilet for people who can afford to pay for the services.
- Routine head shaving to be stopped and adequate delousing measures to be adopted.
- Patients to be encouraged to wear own clothes and more variety in hospital clothing.
- Existing ground space to be utilized to put up a separate building for rehabilitation.

## **Summary and suggestions for the State**

The state of Gujarat has 4 mental hospitals with a total bed strength of 683. While the hospitals in Ahmedabad and Vadodara are medium sized the hospitals in Jamnagar and Bhuj are small. Except in Bhuj, where there is a need to increase the number of beds, the bed strength is adequate. Overall, it appears that it is the individual efforts of the medical superintendents that have helped in preserving some of the basic rights of the mentally ill persons. Working within the constraints of limited financial resources and lack of trained professionals, they have been committed to treating the mentally ill persons with dignity.

One of the positive features is that all the four hospitals have started outpatient services. A particularly progressive step has been taken by the superintendent of the hospital at Vadodara in converting the single cells into rooms where the relative can



stay with the patient. The superintendent in Bhuj has demonstrated that most of the admissions can be voluntary and that with quick turnover there is better utilization of beds.

However, there has to be major shift in the type of care provided from custodial to therapeutic. Since all the hospitals are still functioning with closed wards and without any psychosocial intervention, three basic rights of the mentally ill are violated. These are the right for personal liberty, the right for appropriate treatment and rehabilitation and the right to community and family life rather than a life of incarceration.

The large number of chronic patients in Ahmedabad and Vadodara will remain within the four walls of the hospital unless psychosocial and rehabilitation efforts are not taken up on a war footing. Psychosocial interventions, both at the individual and family level are necessary in order to help these persons reintegrate with the family and community at large.

Psychiatric services have centered around these 4 hospitals, a few of the general hospital psychiatric units and private practitioners in the major cities. The district level posts have not been activated. This has resulted in patients and families having to travel long distances to seek professional care. This has two important implications: 1) Families are forced to admit patients and leave them for long periods of time since they have to earn their livelihood and 2) It prevents recovered persons from being brought regularly for follow-up. As a result, while the patient is in prolonged contact with the mental health facility often developing dependency on the same, the family has minimal contact and is not educated about the patient's illness. This is reflected in the generally low level of community awareness regarding mental illness.

In Gujarat, it is a fairly common sight to see mentally ill persons who have wandered away from their homes languishing in a quiet countryside road or actively gesticulating in the middle of a busy city road. There is an interesting phenomenon of a retired government servant who started feeding the wandering mentally ill and came to be known as 'Pragachi Baba'. Today, in addition to those who reach there by chance, it is said that families are also abandoning the mentally ill person with 'Pragachi Baba' due to lack of other alternatives.

Resources in the community both financial and in terms of voluntary organizations are yet to be fully utilized. There are several organizations, which have expressed a willingness to get involved in mental health care, especially for starting day care centers and sheltered workshops, provided there is active support and guidance from the professionals. The onus is, therefore, on the professionals to seize this



opportunity.

In many of the other states, improvements in mental hospitals have come about as a response to public interest litigation. The Government of Gujarat has already taken a proactive stance and has taken the critical steps that will result in better quality of care for the mentally ill. The specific suggestions for the State are as follows:

- Rules to be framed for the implementation of the Mental Health Act 1987 and compliance with the Act to be monitored and ensured.
- Majority of the admissions should be under the voluntary category.
- All hospitals to have a separate medical records section with a trained person to handle the records. Continuity of records should be maintained from the outpatient till the patient is admitted.
- Ahmedabad needs a new hospital building immediately as many parts of the present structure are not habitable. The absence of proper toilets violates the right to privacy of the mentally ill person.
- The other hospitals require renovation and upgrading of existing facilities.
- All hospitals need proper toilets and bathing facilities with running water and basic amenities such as buckets and mugs.
- Most of the existing wards and all new additions to be built as open wards with provision for the relative to stay with the patient as is the case in a general hospital.
- Family wards to be started.
- Facilities for laboratory investigations to be improved and include estimation of Serum Lithium, VDRL and HIV screening.
- Structured activities in the wards with emphasis on daily living skills.
- Occupational therapy with the focus on pre-vocational and vocational skills.
- Starting of day care centers and sheltered workshops in collaboration with non-governmental organizations and voluntary bodies. These should preferably be located in the community rather than in the hospital. A rehabilitation committee should be set up to administer and monitor the activities.
- Existing vacancies in the professional cadres to be filled up.
- Creation of additional posts for mental health professionals i.e. psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses.



- These posts should carry remuneration commensurate with qualification and designation so as to make them attractive. Other incentives, especially promotional avenues and academic allowance for updating professional knowledge and skills should be provided. Until the vacancies are filled, some mental health professionals may be asked to provide their services on contract basis either part-time or as visiting consultants.
- Personnel already in the cadre who have shown commitment to work can be deputed for in-service training and then given additional increments or promoted if found suitable.
- Intake criteria for group D staff to be modified and 10<sup>th</sup> standard education made the minimum qualification. They should be oriented to working with the mentally ill and designated as nursing aides.
- Other supportive services such as cleaning, gardening and security can be privatized and given on the basis of annual contract.
- Staff at all levels needs to be sensitized about the rights of the mentally ill persons, so that patients, in turn, can be informed of their rights.
- Facilities for the staff such as changing rooms, toilets, drinking water, duty doctor's room, staff room need to be introduced or improved.
- Improved liaison with general hospital psychiatric units and district level hospitals.
- Mental health education to be taken up as a priority.
- A unit of the PWD/Works department comprising of a junior engineer and staff to be posted in the mental hospital to attend to immediate repairs and maintenance.
- Regular meetings (at least once in 3-4 months) of the health secretariat with the four medical superintendents to plan, review and monitor services.
- Inter-departmental meetings to coordinate the work of the various departments such as PWD/Works, Law, Health and Welfare and ensure smooth functioning of the hospitals.



# CHAPTER-21

## JAMMU AND KASHMIR

### INTRODUCTION

Jammu and Kashmir, the northern most State of India comprises of 14 districts of which 6 is in Jammu and Kashmir and two in Ladakh region. Eighty percent of the population depends on agriculture. The official language is Urdu. Other languages spoken are Kashmiri, Dogra, and Ladaki. Literacy rate is 26.17%. The State Administration came partially into force on 17<sup>th</sup> November 1956, and fully on 26<sup>th</sup> Jan 1957. The population is 7.7 million. Agriculture, handicrafts and tourism are the main source of income. There are 2 government medical colleges one at Kashmir and one at Jammu. There is another private medical college in Jammu.

There are 2 mental hospitals one Srinagar (100 beds) and another at Jammu (75 beds). The hospital at Srinagar, Kashmir was destroyed in a fire accident in the early nineties. There are about 30 psychiatrists in the State. Apart from Jammu and Srinagar, psychiatrists are available at Kathur and Dathira. Mental health services are almost non-existent in the hilly and rural areas.

### PSYCHIATRIC DISEASES HOSPITAL, G.M.C., JAMMU

#### Background

This was started as a mental hospital in 1964. It is located 4 kms away from the city center and is attached to the Government Medical College (GMC), Jammu. Buildings are owned and maintained by the Government. Maintenance is adequate and mostly in good condition. There are only open wards, with the total bed strength of 75. Family members are allowed to stay with the patients. Five wards are for males and two for females. Wards are not overcrowded and cleanliness is adequate. There is a separate de-addiction, an isolation ward facility is present. No other specialty sections are present.

#### Staff pattern

The Professor of Psychiatry is also the Medical Superintendent. The other staff are one Assistant Professor, one lecturer, one registrar, 2 assistant surgeons (medical officers), 4 non-PG residents, one psychiatric social worker, 15 general nurses and 14 attenders. There are no clinical psychologists (2 posts are vacant), no psychiatric nurses and no occupational therapists.



## SERVICES

### Outpatient service

There is a daily outpatient service, which is well organized. Outpatient timings are from 8am to 12noon (summer) and 10am to 2 pm (winter). Average number of patients attending the outpatients is about 100 per day. Free drugs are given for 15 days. There are no special clinics. Casualty and emergency services are present round the clock. There are 2 observation beds in the casualty. Routine investigation facilities along with X-ray and EEG are available. However specialized investigations like serum lithium are not present.

Most of the admissions are voluntary and a relative stays with the patient. Decentralized admission and discharge procedure is being followed. Average duration of stay is 30 days. In the female wards the space is not adequate. Patients wear either hospital uniform or their own clothes. Toilet and bathrooms are adequate and properly maintained. Diet is provided at the rate of Rs 14/- per day and is served in hygienic and acceptable way. Quantity and quality is adequate and there have been no complaints. There are only a handful of chronic patients. Direct electro convulsive therapies are administered as there is no anesthetist. Community services are in the initial stages and require to be developed further. There are no rehabilitation facilities.

### Summary

Though the hospital was started as a mental hospital, it is now working as a psychiatric institute attached to the medical college. It has an open ward set up where family members can stay with the patients. This open ward system is an example of how a typical closed mental hospital can be transformed when it becomes an open system. This change has also been facilitated by the attachment to a teaching hospital which has postgraduate students. The effect of adequate staffing is evident on the better care available in this hospital.

### Suggestions

- Modified ECT should be administered. Services of an anaesthetist can be procured on a consultancy basis.
- Rehabilitation services for the mentally disabled should be started immediately.
- Rest home for the relatives should be built.
- Postgraduate courses should be started so that adequate number of mental health professionals can be trained.

Post of clinical psychologists and occupational therapist should be created so that the interdisciplinary team is complete.



# CHAPTER-22

## KARNATAKA

### INTRODUCTION

Karnataka is the eighth largest State in India, both in area and population. It was formerly known as Mysore. On November 1<sup>st</sup>, 1973, it was renamed Karnataka, which literally means lofty land. Karnataka is situated on the western edge of the Deccan Plateau. It has an area of 191,791 sq. km. Bangalore is the capital of Karnataka. Kannada is the State language. Literacy rate is 55.98 % and per capita income is Rs 4075. The sex ratio is 960 females: 1000 males. The State is divided into two districts. The two psychiatric facilities in this State are The National Institute of Mental Health and Neuro Sciences (NIMHANS) situated in Bangalore and the Karnataka Institute of Mental Health (KIMH) located at Dharwad in Northern Karnataka.

### KARNATAKA INSTITUTE OF MENTAL HEALTH, DHARWAD

#### Background

This hospital was established as the Lunatic Asylum, Dharwad in 1845. Until 1947, it functioned under the Bombay Presidency. In 1922 it was renamed as Mental Hospital. Between 1947 and 1956, the hospital came under the Bombay Government, and in 1956, came under the Government of Karnataka.

Until 1960, civil surgeons were on additional charge, but from 1960, a psychiatrist has been in independent charge as superintendent. In 1966, the KIMH became a teaching hospital, recognized by the Karnatak University. In 1965, outpatient services were started. From 1980 and until 1991 post-graduate programs were conducted, but discontinued because of lack of adequate staff. In 1992, it was renamed the Karnataka Institute of Mental Health.

The hospital is situated 1 km from the city centre. It caters to about 16 districts of Karnataka and other places like Goa, Kurnool and Kolhapur.

#### Staffing pattern

There are 375 patients (250 males and 125 females). There are only 2 psychiatrists. Of the four medical officers, one is a radiologist, one a pediatrician and another an obstetrician. There are a total of 167 staff, including 3 clinical psycholo-



gists, 1 psychiatric social worker, 41 nurses and 97 attenders. There are no occupational therapists. The staffing is perceived as inadequate. The KIMH has come under the attention of the courts recently, which has directed the Government to fill up specialist posts. Rs. 25 lakhs has been sanctioned towards improvement. There are still vacancies among ward attenders. The medical staff work from 9am to 4pm, while the others work in 3 shifts. Although there are shortages in the staff, the staff morale is high. The then superintendent effectively handled problems among attendants. He has been largely instrumental in bringing about functional improvements and improving discipline despite constraints.

## **Infrastructure**

The wards are distributed over a large area. They are predominantly closed wards. Buildings are in a state of disrepair. Individual cells are present but infrequently used. Many of the single cells have been converted to private rooms. A high wall surrounds the female wards.

There is a lack of running water for the toilet and for bath. Patients are expected to walk to the storage tank to collect water. Some of the toilets are badly clogged.

The approach to the hospital has been altered giving it a more general hospital kind of ambience. A new block for outpatient and short stay has been built but is not in use due to shortage of staff.

## **Admission and discharge**

Admissions occur under the Mental Health Act 1987. A majority of the admissions are voluntary. There are about 2000 voluntary admissions annually. About 63 to 91 patients were admitted under court order each year during the five year period of 1992-96. Deaths during this five-year period have declined from 17 to 6. There have been no suicides in the last 5 years.

The hospital has successfully brought down its long stay. However a third of patients have been in the institution for more than 2 years. Currently, average duration of stay is 25 to 35 days. Eighty percent of the patients are sent home with their relatives. Twenty seven percent get readmitted during the following year, because of drug default, financial problems preventing regular follow-up and misconceptions about the need to continue treatment.

Discharge problems, in addition to routine problems, include external pressure to detain patients in hospital.

The hospital has been working with the magistracy to prevent frequent readmission, and encourage voluntary admissions to prevent involuntary admissions.



## **Finance**

Over the 5-year period (1992-96) plan budget has increased from Rs. 50,000 to Rs. 2,00,000 and non-plan from 98,85,000 to Rs. 1,82,20,500. Fifty seven percent of the expenditure is on staff salaries, about 12% for food, and 14% on drugs.

Donations have been received for recreational items, construction of a prayer hall, and for drugs.

## **SERVICES**

### **Casualty and emergency service**

These services are present and easily accessible. Only about 3-4 cases are brought per week. Most patients are admitted. Ambulance services are provided. There is no short stay facility. No emergency investigations are provided.

### **Outpatient service**

Daily outpatient services are available between 9am and 4 p.m. catering to about 150 to 180 new and follow-up cases. Almost 3-5 patients are still brought in chains every week. The doctors are posted by turn to the OPD. There is a waiting hall. Separate interview rooms are available for patients. A nominal fee is charged for the case file. Free drugs are provided for 15 to 60 days. However, few of the newer anti-psychotics or mood stabilizers are available among the free drugs.

### **Inpatient service**

The wards are clean. Adequate cots, mattresses, linen and warm clothing are provided. However, patients are mandated to wear uniforms. Shaving of head is routinely done for all males once in 3 months. Toilets are adequate, but the lack of running water and poor maintenance warrant immediate attention. Some recreational facilities are provided in the wards. Anti-lice and bug measures are adopted quarterly. Majority (95%) of the patients are free voluntary boarders. There is a separate duty room for the doctor on call. Two hospital attendants manually wash patients clothes. The Institute recognizes the need for a little privacy to patients, and a need for increase in living space.

### **Dietary and pantry facility**

Rupees sixteen is allotted per day for diet and Rupees twenty for special diet. Breakfast is served at 7 a.m., lunch at 12 noon, coffee at 4 p.m. and dinner at 7 p.m. About 2000 calories are provided per patient. Four cooks, under the charge of the staff nurse, prepare the food. There is no separate dietician. Food containers are



carried to the ward by patients. Cooking is done by gas. Patients have no separate dining facility.

### **Investigations and treatment facility**

Only basic blood tests and X-ray is available. There are no facilities for lithium estimation, or screening for sexually transmitted diseases. Psychological testing is available. Only paying patients are charged for investigations.

Both direct and modified ECTs are administered in the ward after sending out other patients. This is very unsatisfactory and a separate place must be immediately identified.

### **Medical records**

Separate records are maintained for each patient and manned by 2 staff in the records department.

### **Rights of patients**

No information on illness is routinely provided to patients and families. There is a great need to sensitize the ward staff to these issues. However, patients' morale was found to be high.

### **Services and facilities**

There is adequate electricity and water supply. Wards are connected by inter-com. Some recreational and reading facilities are provided for patients. No canteen facilities are available.

### **Board of Management**

The Board has been constituted but has not been meeting.

### **Rehabilitation services**

An NGO, Soumanasya, is functioning in the campus of the KIMH, but meets rehabilitation needs of only about 10-12 patients. None of the other patients have any psychosocial rehabilitation program. There are two long stay facilities catering to 90 patients. There is no active liaison with other voluntary agencies / NGOs

### **Community services**

There is hardly any community programs undertaken by the KIMH, mainly because of a lack of psychiatrists. However some services are provided to the State homes, and a weekly clinic is conducted at the general hospital at Hubli.



## **Staff training**

Meeting between the Medical superintendents and medical / paramedical staff were being held every 2 months and with the attenders every 6 months. However, there are no in-service training programs for the staff. There is a need for regular programs for all levels of staff to update their knowledge and skills. Improvement of amenities and incentives for staff must be examined.

## **SUGGESTIONS**

- There is an urgent need for trained manpower.
- Many of the wards are in a state of disrepair. Appointing a PWD official full-time to oversee such problems may be a solution.
- Toilets need urgent attention as most of them are not non-functional.
- Running water must be immediately provided.
- Some structural changes need to be carried out in order to offer some privacy to patients.
- Practice of direct ECTs must be discontinued. Separate place for ECT administration must be identified, and ECT given under supervision of an anesthetist.
- Automated washing facilities should to be provided (There is a modern morgue but no automated facility for washing!)
- Better facilities for transport of food to the wards should be introduced.
- There is a need for trained psychiatric nurses.
- Ward attenders should be sensitized about the rights of the mentally ill.
- There should be greater emphasis placed on rehabilitation.
- Need for better community liaison including awareness and education about mental illness.

## **THE NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES (NIMHANS), BANGALORE.**

### **Background**

The psychiatric facility had its origin in the lunatic asylum in the Pettah in the middle 1800's. However, overcrowding at the asylum, and the location in the middle of the city not "being conducive to promoting mental well being" were evident in the latter part of the nineteenth century. Further, no more buildings were possible in the old complex. Thus in the 1920's the Maharaja of Mysore approved construc-



tion of a new asylum, and the second highest hillock in Bangalore was chosen as a site for the new asylum, meant to house 400 - 500 patients. The building, presently in use and its adjoining garden were carefully designed by Sir Mirza Ismail. The services provided at this asylum and the institution were thought to be unique and described by Mapother in 1938 as a 'monument to the vision and wisdom of all those responsible for the mental defectives in the east'. The present premises started functioning in 1937. In 1954, the All India Institute of Mental Health was created and became India's first post-graduate training centre. In 1974, mental health and neuro sciences were brought together to form the National Institute of Mental Health and Neuro Sciences. The institution is presently a Deemed University.

NIMHANS is situated 8 kms from the city centre. It caters to patients from Karnataka, Andhra and Tamil Nadu, as well as to other States in the country.

### **Infrastructure**

The hospital offers in-patient services in psychiatry, neurology and neurosurgery (the latter two being located in the Neuro centre). Psychiatric facilities include 2 closed pavilions, 7 open wards and two paying ward blocks accounting for 650 beds. Separate facilities are provided for children (20 bedded ward), family therapy (14 rooms), alcohol and drug de-addiction (60 beds, also a closed facility). There are separate chronic wards where stabilized patients unable to return home or be placed outside lead a semi-independent living.

All patients are provided mattresses, cots and linen. Hot water is provided in the wards. Capacity at the time of evaluation was 482. The Government is responsible for building maintenance, and an Assistant Engineer is posted in the campus to supervise PWD work.

Some of the buildings are old and need repair. The open wards were built as sheds and require redesigning.

### **Staff pattern**

There are about 46 psychiatrists (including faculty and senior residents), 28 clinical psychologists and 26 psychiatric social workers, 138 trained nurses, of whom only 36 are psychiatrically trained nurses and 143 ward attenders. The psychiatric services are administered through a unit system, with a multi-disciplinary team comprising of a psychiatrist, psychiatric social worker, and clinical psychologist. Separate Departments of psychiatric social work, psychiatric nursing and clinical psychology are present. Separate staff are present for the Department of Psychiatric and Neurological Rehabilitation.

There are 20 vacancies of attenders, 53 vacancies of trained psychiatric nurses and 22 vacancies of general nurses at the time of evaluation.



Neurological and neurosurgical Departments offer referral services to psychiatry. There are supportive laboratory, radiological, speech therapy services and basic sciences facilities through various departments. There are visiting consultants in medicine, surgery, orthopedics and ophthalmology attached to the Institute. Many of the staff, including the Medical Superintendent and Resident Medical Officer (totaling 391) stay in the campus. Either the Medical Superintendent or his Deputy is a psychiatrist. Pay scales are in accordance with Central Government Scale. Working hours of all staff is between 9 a.m. to 4.30p.m.

### **Admission and discharge**

Procedure of admission and discharged follow those outlined in the Mental Health Act of 1987, although all procedures have not yet been formalized. Some referrals from the magistracy still come under the Indian Lunacy Act. Between 1992 and 1996, voluntary admissions have increased from 3601 to 4478 annually. Involuntary admissions have ranged between 45 to 51 annually across this time period. Deaths per year have declined from 23 in 1992 to 12 in 1996. There has been 1 suicide and 1 homicide during this period. One hundred and eleven patients have been in the hospital for more than 5 years. Average duration of in-patient stay is 47 days. Proportion of readmission during the previous year was 0.24. Police, the media and voluntary agencies are involved in tracing patients' families and placing patients when families are unwilling or unable to accept patients.

### **Finance**

Allocation for the entire institute has increased from Rs. 8.55 crores in 1992 to Rs. 12.7 crores in 1996 (non-plan) and from 4.36 crores in 1992 to Rs. 6.84 crores in 1996. It must be emphasised that this is a common budget for psychiatric, neurological, neurosurgical and basic science Departments. Donations are accepted by the Institute both in cash, equipment and other assets.

Currently the major financial allocation for the Department of Psychiatry is toward construction of a new child psychiatry wing.

### **Casualty and emergency services**

Common services for psychiatric and neurological / neuro surgical emergencies are provided 24 hours and are easily accessible. About 40 psychiatric emergencies are registered weekly. There are 6 short stay beds are provided. Ambulance facilities are adequate.

All supportive investigations, hematological, bio-chemical, radiological (including CT and MRI are available). Emergency medications are all available. Junior and senior residents are posted for emergency duties and a consultant psychiatrist is on call.



## **SERVICES**

### **Outpatient**

Daily outpatient services are provided on all weekdays, between 8am to 5pm. However, new cases are registered only until 11 am and thereafter only emergencies are registered. About 300 to 350 cases and 5-8 emergencies are seen daily in the outpatients. Seating accommodation in the waiting hall is provided for about 80 people which is not sufficient. Waiting period for follow-up sometimes extends to several hours because of the patient load.

A registration fee has been recently introduced. Fifty to seventy five percent of patients receive free medication for a month. However, none of the newer medication (anti-depressants, anti-psychotics or mood stabilizers) is available free.

A dharmashala has been constructed to provide accommodation to families.

### **Inpatient service**

There are adequate cots, mattresses, and linen for patients. Patients are seen regularly by nursing and medical staff. Recreation facilities are provided in each ward. Patients are encouraged to wear their own clothes. For others, uniforms (in 5 sets each) are provided, consisting of half shirt and pajama / shorts for male, and blue saris / gowns for females.

While in the closed wards, there are adequate toilets (1 for 5 patients); these are inadequate in open (often-just one for 20 patients and their attendants) wards. There is little privacy for patients and their families. Records are well kept. Shaving of head is not routinely done, but sometimes done for a few chronic patients, when chemical delousing does not work or is thought to be unsafe. Shaving facilities are provided once in 2 days and haircuts provided in the ward. Anti-lice and bug measures are adopted quarterly.

Majority (95%) of the admissions are voluntary and about 80% are treated free of charge. Recently a nominal fee of Rs. 8/- day has been instituted, which can be waived off by the admitting unit. Paying patients are charged on different tariffs depending on the income. One large seclusion room is available in each of the two pavilions. Families are encouraged to visit and bring lunch for patients in the closed wards.

### **Dietary and pantry facilities**

There is a modern kitchen under the supervision of dieticians. Breakfast is served at 6.30 am, lunch between 12.30 to 1.00 p.m., coffee between 3.00 and 3.30



p.m. and dinner between 7 and 7.30 p.m. Approximately 2750 calories / day are provided at the expense of Rs.20/- on general diet and Rs.40/- on special diet.

Water coolers are available in only 1 ward, but recently filters have been made available in the closed wards. Food is transported on mechanized trolleys. It is served in the verandah.

### **Investigations and treatment facilities**

All routine investigations, psycho-diagnostics, radiological investigations (including scanning), drug level estimations are done. Various non-pharmacological treatments are available. Only modified ECT's are used.

### **Medical records**

A very well organised medical record section with independent staff is present. Confidentiality of records is maintained. Individual files are maintained for each patient. The record section is presently being computerized.

### **Rights of patients**

All patients in closed wards are encouraged visits by the family and encouraged to write letters home. Improved patients are shifted to the open wards along with a relative as soon as possible. There is active liaison with voluntary agencies, aftercare homes, nursing colleges.

### **Services and facilities**

Electricity, running water, drainage is adequate. Telephone facilities are provided. Canteen facilities are present. There is a library and documentation centre with access to internet for trainees.

### **Board of visitors / Management**

The Board of Visitors no longer deals with decertification of patients. Two independent psychiatrists do this.

### **Rehabilitation services**

A separate department with 15 different fully operational sections provides rehabilitation to both in-patients and outpatients, mentally ill and mentally retarded. The focus is on providing occupational therapy to improve attention span and work habit. The rehabilitation centre liases with 4 different halfway home facilities in the area, as well as voluntary agencies and various NGOs. The facility can accommodate 300 clients. One hundred and fifty persons were availing the programme at the



time of evaluation. One to two clients are placed in open jobs each month. Patients are formally assessed and paid incentives. Facilities for selling products are provided. Separate staffing for the Rehabilitation Department (including occupational therapists, vocational instructors, rehabilitation assistants are provided). There are separate faculty incharge of these services (both psychiatric and neurological. Other departments lend additional support).

However, there is a perceived need for separate clinical psychologists and psychiatric social workers in this area.

### **Community service**

NIMHANS has a full-fledged community mental health unit, which runs a rural mental health centre at Sakalvara, and 5 extension clinics on a fixed basis every month. It also runs weekly clinics at the Anekal Primary Health Centre. NIMHANS has been actively involved in implementation of the National Mental Health programme and developed a model District Mental Health Programme in Bellary District. Training of PHC personnel, training of NGOs., outreach programmes in rehabilitation and for alcoholism, regular visit to the jail to provide psychiatric services are some of the numerous activities undertaken by NIMHANS. Many of its faculties are involved in education and awareness activities in the area of mental health.

### **Staff training**

Regular meetings are conducted between the medical, non-medical mental health staff and nursing staff. The nursing administration co-ordinates training programmes for nurses and attendants. Burnout is not very common at NIMHANS possibly because of better service conditions compared to other mental health care institutions. NIMHANS also has a reasonable public image of a good Government Hospital-cum-Research and Training Centre, with efficient services, good quality doctors and other staff, who are generally perceived to be hardworking and technically very competent.

### **Summary**

The good image generally enjoyed by NIMHANS has led to steadily increasing clinical load both in the inpatient and outpatient. This is slowly and visibly compromising the quality of care. Although the number of referrals has been steadily increasing the staff strength has remained consistently the same. Although NIMHANS is a significant contributor to training, research, policy formulation at a national and international level, when it comes to basic clinical care constant efforts need to be made to ensure optimal care.



## SUGGESTIONS

- Structural changes and regular ward repairs must be made.
- New and safer drugs free of cost must be provided to patients, especially for out-patient care.
- Better toilet, water cooler facilities in all wards, especially open wards must be provided.
- Open wards must be re-built with better amenities for family members.
- More intensive family education about mental illness and their treatment must be provided.
- Out-patient services must be better organized with more seating, lessened waiting time.
- Dining facilities for in-patients must be provided.
- All levels of staff must be sensitized.



# **CHAPTER-23**

## **KERALA**

### **INTRODUCTION**

The State has an area of 38,863 sq.km. and a population of 29,011,237 with 4,218,167 males and 14,793,070 females. There are 1040 females to every 1000 males. The capital is Thiruvananthapuram and the state has 14 districts. The density of population is 747 persons per sq.km. with an urban population of 26.3%. The literacy rate is 90.6% and per capita income is Rs. 5065/-. The state has three mental hospitals in Kozhikode, Thiruvananthapuram and Thrissur with a total bed strength of about 1400. There are psychiatry units in all the medical colleges at Kozhikode, Kannur, Thrissur, Kottayam, Alleppey and Thiruvananthapuram. There are also many private psychiatric hospitals with the total bed strength exceeding 2000. This chapter will describe the findings of the three government mental hospitals.

### **GOVERNMENT MENTAL HEALTH CENTRE, KOZHIKODE**

#### **Background**

This hospital which was established in the year 1872 and is situated about 3 km from the centre of the city. It was originally started with 9 beds as a Lunatic Asylum under the Inspector General of Jails. In 1886, the number of beds was increased to 84 in 1935 to 377, in 1940 to 502 and from 1970 onwards it has 700 beds. The name has changed from Lunatic Asylum to Government Mental Health Centre in 1986. This was governed by the Madras Presidency till 1945 and later by the Government of Kerala. The catchment area of this Centre is mainly the six districts of the Malabar region and some patients from the neighbouring states. This hospital celebrated its 125<sup>th</sup> year in November 1997. The jail is situated about 2 km from the hospital.

#### **Hospital infrastructure**

There are 7 closed wards with cells, 1 open ward, 10 paying rooms, 1 family ward, 1 male and 1 female criminal ward. All the old wards are in a terrible state of disrepair. A new building (closed Pavilion type) is awaiting opening. In the general wards, medicines, clothes and food are supplied free of cost. No extra facilities are available in the paying wards except for a separate room and toilet. Though the sanctioned bed strength of this hospital is 474 the current occupancy is 750-800 patients at any point of time. There are many cells where numerous patients are



squeezed into a single cell with a single open toilet in the corner. There is no place for them to lie down. Only some patients have some mats. The rest sit or lie on the wet, cracked floor. These patients eat their food with plates kept outside the barred doors! These cells are some of the most inhuman ones in the country. All the buildings are government buildings, and the Public Works Department supervises the maintenance. Security in the criminal wards is not adequate and these patients are mixed with the non-criminal patients. There are plenty of old buildings that are to be replaced at the earliest.

### **Staffing pattern**

The Medical Superintendent is the administrative head with a Lay-secretary as assistant. Actually many posts of psychiatrists are vacant and medical officers of other disciplines are managing the patients. An interesting feature of this mental health centre is the presence of another Institute inside the campus, called the Institute of Mental Health. The post of Director and 2 psychiatrists at this Institute are vacant and the Medical Superintendent is holding the additional charge of Director.

Four qualified psychiatrists from the Medical College Hospital and their post-graduates are posted here as part of their training program. These psychiatrists, on rotation, manage two clinical units.

The other staff are 1 clinical psychologist, 47 general nurses and 37 ward attenders. There are no posts of occupational therapists and no trained psychiatric nurses. The staff structure is highly inadequate for the number of patients. Doctors work for five hours. Regular meetings of the medical staff and nurses do not take place.

### **Admission and discharge**

The procedures are followed partially by the Mental Health Act, 1987. There was a difficulty with regard to the court procedures, as some courts still followed the Indian Lunacy Act, 1912 and some followed the Mental Health Act, 1987. Medical Superintendent and judiciary do the admission. A large number of long stay chronic patients are present. Many of these patients have recovered and are fit to go home. They are not discharged by the hospital authorities for fear of reprimand by the public or by state government officials and politicians. Problems in discharge occur as the relatives do not turn up for taking the patients home even when they are fit for discharge. The staff reported that relatives brought patients and demanded admission even if the patient did not require it. There were instances of relatives getting belligerent and using political influence to keep patients in hospital. Patients have a right to appeal grievances but there is nobody to help them do it.



## **SERVICES**

### **Casualty and emergency service**

Casualty services are easily accessible and available for acute psychiatric emergencies. Medical emergencies cannot be managed in the casualty. There are six short stay beds for observation of patients. Ambulance facility is present. Routine preliminary investigations of urine and blood are available. Routine medicines are adequately available. Facilities in the casualty are highly inadequate in terms of the space, trained personnel and furniture.

### **Outpatient service**

Outpatient services are run on a daily basis with highly inadequate staff. There is a waiting hall for the patients in the outpatient, and common drugs available for patients are free. Interview rooms are inadequate and there is no privacy for the patients. Records are maintained in the record library. About 20% of the case files are non-retrievable due to inadequate staff in the medical records section.

### **Inpatient service**

The wards are crowded and proper identification and treatment of patients is impossible. As the staff strength is too low the nurses and doctors cannot identify the patients or the treatment they get. Whenever a patient gets excited they are restrained and medicated. The patients who are better are also mixed with acute patients. Budget for drugs is inadequate. Due to the large number of patients there is lack of supervision of medicine intake. Direct ECT is given. Only routine blood and urine investigations are available. All other investigation facilities are below standard. Psychosocial therapies are generally not provided. There are separate case files for the inpatients. Record maintenance in the case files is poor. Notes are inadequate. Records of menstrual charts, weight and other vital functions are not maintained. A typical day's activity consists of maintenance of personal hygiene of the patient, food and medication distribution and recreational activities for some patients. Patients are reportedly given bath daily and have a daily change of dress but it was seen that many of them were dirty or infested with scabies or lice. Linen is apparently changed once in 2-3 days. There is a power laundry available. Cots and mattresses are highly inadequate. Approximately 80 single room cells with iron bars and gates are present and these are used regularly. Majority of the patients in the cells are provided with only a single mat. They do not have clothes or sheets to cover themselves. There is no mosquito proofing in any ward. Basic facilities in the wards are highly inadequate.

No facility is available for keeping patients' belongings in the ward. Hair cuts



and shaving is done adequately. Anti-lice measures are undertaken quarterly. Ninety nine percent of the patients are non paying. Budget allocation is inadequate. Donations are received in kind and are not adequate. A diet of Rs.22/- per head is provided. The quantity is not adequate as it is distributed to double the number of patients. Both gas and fire wood are used for cooking. Complaints regarding the taste of the food, inadequate cooking, and a lack of variety are a common feature. It is necessary to have improvement in the taste, proper cooking and variations in the menu. There is no proper waste disposal system and hospital wastes are piled up outside the wards and food waste is thrown into deep open pits. These pits fill with rain water and breed flies and emanate a bad odour. The hospital campus is not cleaned or tended and is overgrown with weeds. There is running water available. However, water supply is erratic and there are insufficient storage tanks. Water storage capacity is not adequate considering the number of patients. There are no water coolers and food is supplied with patients wandering around. Electricity facility and campus lighting is inadequate. There is no generator facility. In general, telephone facility and library facility are inadequate. No newspapers are provided for the patients. Some rudimentary recreational activities are present, but no specialised staff is appointed for this work.

Rehabilitation services in this hospital are present at the new Institute for some patients. An excellent book binding section and a spinning section is present in the Institute of Mental Health. Day care facility is available for 2-3 patients in the book binding section. There are no separate rehabilitation wards. There is no long stay facility. Rehabilitation programs are separate for both males and females. The total number of beneficiaries is around 60. No job placements are done from the centre. Finished products are sold but no sales counter is available. Patients are used for routine hospital work like cooking, cleaning, and bringing food. Only patients working in the rehabilitation centre are provided with incentives based on the quality and accuracy of the work done by the patients. No formal assessment of patients is done before and after attending the rehabilitation facility. About five different voluntary organisations, which are registered non-government, organisations do interact with patients here. Mental retardation certificate is issued by the Medical Officers to avail disability benefits. No special staff posts are available there for rehabilitation activities other than the two temporary instructors. There is a lack of trained staff and space in the rehabilitation centre. There is a need to develop a good rehabilitation centre with adequate staff, as this is a nucleus of rehabilitation activity for the mentally ill patients.

### **Community services**

There is no community service extended by the mental health centre, but the Institute of Mental Health conducts camps in two neighbouring districts. Since the



last 2 years they provide training for doctors and paramedical staff of mental health. District Mental Health Program has not been implemented so far. Hence, no community support services are available.

### **Rights and legal issues**

Rights of the mentally ill are not known to either the patients or the staff. Even though it was mentioned that all the staff members are aware of the rights of the mentally ill, on interview it was found that they were not. The conditions in the wards are so pathetic that patients neither get proper treatment facilities nor are they treated with dignity. Patients reportedly write letters to their houses but do not get a response. They are allowed to talk to social agencies. There is some liaison with NGOs'. These voluntary agencies have been trying to do something to improve conditions and have filed public interest cases in court. The Board of Visitors is present but not meet regularly. Therefore regular inspections do not occur. The District Collector is the Chairman of this Board. The Mental Health Act is not fully complied with, as there is lethargy from the side of both the administration and government. This hospital also comes under the Monitoring Committee set up by high court.

### **Summary**

This mental health centre ranks among the worst hospitals in the country. The conditions in the wards are characterised by over crowding, dilapidated facilities, bad hygiene and care. The patients do not get standard psychiatric care, which is their right. Even after recovery they are confined in the hospital against the law. There is interference in the process of admission and discharge by politicians and government officials. There is evidence of staff burnout as observed by a lack of motivation and inertia of the staff. This is due to overcrowding, poor working conditions and absence of trained staff. There is an urgent need for intervention here to assure rights of this large population of mentally ill deprived of their rights.

## **MENTAL HEALTH CENTRE, THIRUVANANTHAPURAM**

### **Background**

This hospital was started by the Maharaja of Travancore in 1817 as a Hospital for Incurables (tuberculosis, leprosy, insane). It is situated 4 km from the city centre. During the post independence period, the hospital was run by the Government of Kerala. The earlier name of this hospital was Hospital for Mental Diseases and in 1985, the name was changed over to Mental Health Centre. This hospital caters to patients of the neighbouring districts of Kerala and some districts of Tamil Nadu. It is in close proximity to the jail.



## **Hospital infrastructure**

There are 11 closed (pavilion and cell) wards, 4 open wards, 6 paying wards, 3 family wards, 1 alcohol and drug abuse ward, 2 criminal wards and 4 chronic wards. There is one day care and rehabilitation centre. All basic facilities are supposedly available in the general wards. In the paying category, separate rooms are available. The actual bed strength of the hospital is 463, of which 341 is for males and 116 for females with 6 wards for paying patients. The actual patient strength of the hospital was 832 as on the day of the visit (July 1998). The hospital has a Superintendent, Deputy Superintendent and an office headed by a Lay Secretary. The administrative set up seems to be adequate. Buildings are reasonably well maintained. All buildings are government buildings maintained by the Public Works Department. There are large numbers of very old buildings that require immediate renovation.

## **Staffing pattern**

There are 8 posts for qualified Psychiatrists, 4 for General medical Officers, 2 Clinical Psychologists, 1 Psychiatric Social Worker and 52 Nurses. There is a post of occupational therapist. Nursing assistants called Nursing Aids are 130 in number. There is a Dietician and a Medical Records Librarian. The Resident Medical Officer and some of the staff nurses stay in the campus. The staff position is not adequate for the actual number of patients. There are only 3 staff nurses who have undergone training in psychiatric nursing and most of the other staff members do not have an in-service training program. Working hours of doctors is from 8 a.m. to 1 p.m. However, effectively, only 3 1/2 hours is spent in the hospital. For other staff members working hours are for 8 hours.

## **Admission and discharge**

Most of the admissions are voluntary. The involuntary admissions are through magistrate orders for both wandering patients and criminals. There is partial compliance with The Mental Health Act, 1987 and the admitting authorities are the psychiatrists and the judiciary. Even though the rights of the patients are reportedly communicated to them at admission, on enquiry it was found that the patients are not fully aware of the rights. Majority of the patients have been staying in the hospital for more than 1 year and a large number of patients are there between 5 and 10 years. Average duration of stay is calculated as 67 days per patient and more than 50% of the patients are repeat admissions. The reasons for repeat admissions are poor drug compliance, poor psychosocial support and poor community mental health care. The hospital authorities do the de-certification. Patients are usually discharged through their relatives. A significant problem with discharge is the lack of initiative from the relatives to take these patients home, especially in the case of female patients. As this hospital does not have any provision to collect a deposit at



the time of admission (i.e. 3 times the bus fare), the hospital authorities find it difficult to send these patients with an escort from the hospital. It was observed that there was pressure from government officials and politicians on the hospital authorities to admit and not to discharge even recovered patients. The hospital authorities are put in an ethical dilemma. The government should initiate necessary action to avoid this situation. This type of pressure increases the number of patients in the hospital compared to the sanctioned strength and this tells on the quality of service given. Similarly, the family members and the community are reluctant to take the patients back home even though patients are cured. There are only few personnel, especially psychiatric social workers, in the hospital, who can be effective in improving the discharges. In case of grievances, patients have a right to appeal. The budget allocated is not adequate in terms of the magnitude of service requirements and the Government of Kerala provides the whole budget. There is a large potential in this hospital to mobilise internal resources. The services can be further improved.

## **SERVICES**

### **Casualty and emergency service**

Casualty and emergency services are present and are accessible for patients. Majority of the emergency patients (70%) are admitted to the wards. Short stay wards are in the form of single cells. There is an ambulance facility available in this hospital and it is available from 8 a.m. to 5 p.m. Minimal required medicines are available in the casualty but there is no telephone facility available. Staff members are inadequate and the quality of the equipment in the casualty is in a very poor shape.

### **Outpatient service**

Outpatient services are run on a daily basis. Outpatient services are from 8.30 a.m. to 1 p.m. and 3.30 p.m. to 5 p.m. On an average, 33 patients are screened per day. Trained psychiatrists and medical officers are present in the OPD. Average waiting time for the patient to see the doctor is one hour. There is a waiting hall with seats for the patients and relatives and 25% of the people can be accommodated here. Most of the commonly used drugs are given free to all the patients. There is an urgent need for a short stay observation ward.

### **Inpatient service**

In the wards none of the patients have a proper activity for the whole day. It is reported that daily rounds of the inpatient wards are done. The general cleanliness of the cells and family wards are bad. Patients are supposedly given a daily bath and change of dress once in 2-3 days. Linen on the bed is reportedly changed once in a week. Patients are allowed to wear their own dress. There is no uniform. Ratio of



toilets, cots and beds are adequate in the new wards. No chairs are provided in the wards, no fans are provided in the old buildings. Privacy is absent. Rudimentary recreational facilities are available in some of the wards. There is no facility for keeping belongings for the patients. No shaving of heads was noticed. There is provision for monthly hair cut and weekly shaving for males. There is no provision for inpatient emergency care. This is a very serious issue to be addressed in almost all mental hospitals in Kerala. They have facilities for anti-lice measures. Anti-mosquito measures are totally absent. There are plenty of cells with iron gates, which are used on a regular basis especially for acutely ill. The visiting hours are 10 a.m. to 1 p.m. and 3 p.m. to 5 p.m. but hardly any relatives visit. Facilities in the inpatient set up are generally very inadequate due to overcrowding and poor upkeep. It seems that even the staff members who are working in the whole area are not concerned about the overall cleanliness of the place.

The food is provided as directed by the diet schedule prescribed by the government and a dietician is in charge of the food along with the Resident Medical Officer. Cost for diet is Rs.20/- per day and diet seems to be inadequate. This hospital is using closed containers for food supply and pantries are hygienic. No regular screening of the cook and foodstuff for communicable diseases is conducted. Food is served in plates and cups in dining hall and the patients had frequent complaints about the quality and quantity of food supplied. . The provision of drinking water is by mud pot with a dipper. There are no water filters or coolers despite the hot climate.

Minimal basic psychiatric facilities are available and the hospital uses drug therapy and direct ECTs. Physical restraints, seclusion, drug therapy and combination of these are used for controlling violent patients. Investigation facilities for lithium, blood chemistry, ECG, EEG and X-ray are not available. No provision is provided for modified ECTs'. Each patient has a separate case file. Confidentiality is maintained. Records are stored in the medical record library. However, the contents of the case files do not have adequate and frequent notes of the patients' progress. There is an urgent need for doctors to examine the patients daily in case of acutely excited patients and at least once in 2 days for the less acute and once in a week for chronic patients. Relevant notes to be entered in the case files.

This hospital has a large campus, which is not very well lit. This causes great inconvenience for the staff at night when they go around the ward to check if there is a problem. When there is a power cut, there is no alternative arrangement like a generator. Similarly, intercom connections between wards are not provided. If any patient becomes violent or in case of emergency, the nurses find it very difficult to contact the doctors. The drainage and water facility in the campus is poor. There is a canteen available for relatives but this is not sufficient as it serves only snacks and beverages. The library facilities for patients and staff are minimal, as there are no



daily newspapers or magazines for the patients. Only 200 - 300 old books are available and these too are poorly accessible. Very few recreational activities are available.

There is no separate rehabilitation ward or a sheltered workshop in the hospital. Occupational therapies like sewing, making covers and craft are present for a selected few patients. There is a day care facility run in the hospital premises in association with an NGO. There is regular production and sales. There is no rehabilitation for long stay patients and no organised programs for any of the inpatients. Patients are used for routine hospital work without providing them any remuneration. No formal assessments of patient or therapeutic measures are employed for disabilities. There are no facilities for volunteer participation in rehabilitation. There are no trained staff for rehabilitation work. Thus there is an obvious lack of rehabilitation activity in this mental hospital.

### **Community services**

No community services are run by the hospital, apart from training of doctors, nurses and ward staff. As some of the wards are attached to the medical college, postgraduates are posted here from the medical college department. Paramedical students are also posted. No district mental health program is running in the state as envisaged by the NMHP. There is provision for mental health care at general hospital psychiatric units. The psychiatrists occasionally visit the jail. No provision for extension of mental health services for the community is there at present.

### **Staff training**

Meetings of all the staff do take place at least once in a month and occasionally, there is an in-service training program for medical staff. It is reported that there is a 50% staff burnout for the people working in this hospital. Common reason stated for the poor work ethics in the mental hospitals are overcrowding and over work. Majority of the staff at the level of nursing aids are transferred to the mental hospitals on punishment transfer for offences like molestation, alcohol and drug abuse, physical assault etc. These groups of staff members are generally not interested in doing their own work. Majority of them are not at all trained in the care of the mentally ill. An area that requires urgent attention of the state government is the revamping of staff structures and staff punishment transfers. In this regard, the fact remains that the schemes for mental health are not implemented appropriately. The lack of concern for the mentally ill is not from the staff working there but with the government.

### **Rights and legal aspects**

The report says that rights of the patients are ensured. However, most of the patients and staff are not aware of this issue. In this regard, there is a need to provide information for the full rights of the mentally ill to the staff members, patients,



relatives and volunteers. It is advisable to display the rights of the mentally ill in the outpatient and inpatient wards. There is an active liaison with volunteer agencies and at least once a week, they come to the hospital. Some of them have formed a human rights group, which has, over the years, campaigned for opening up the hospital and involved in patient rehabilitation. There is a Board of Visitors but they do not inspect regularly. Discharge of improved patients get delayed as relatives do not turn up and the hospital has difficulties in discharging patients on their own. There have been complaints by the public and political intervention when recovered patients were discharged alone. There are a large number of court representations and varieties of commissions have visited this hospital in the past. The amount of improvement is not commensurate with the efforts put in by the experts and the judges in the past.

## **Summary**

This mental hospital in the capital is better than the one in Kozhikode in terms of facilities and better staffing though not adequate. However the problems that plague the earlier hospital in terms of overcrowding, inadequate standards of psychiatric care and poor maintenance of the infrastructure is the same. So also are the infringement of patients' rights in terms of proper treatment, respect and dignity of the individual. The more serious problem is the illegal confinement of persons who are well and non-compliance with the Mental Health Act. The interference by government officials and politicians in the functioning of the hospital is deplorable and the judiciary has been unable to improve matters significantly despite commissions and monitoring committees.

## **GOVERNMENT MENTAL HEALTH CENTRE, THRISSUR**

### **Background**

The Maharaja of Cochin started this hospital as two rooms, in the year 1889. Since then it has been continuously providing service for the past 108 years. It is situated 1 km away from the heart of the city. It was originally called as the Hospital for the Insane. Till 1956, this hospital was managed by His Highness the Maharaja of Cochin. After 1956, the management of the hospital has been done by the Govt. of Kerala. This hospital was re-named as Mental Health Centre in 1984. It is situated 6 km away from the Central Jail, 1 km from the District Hospital and 1 km from the Medical College Hospital. The catchment area of this health centre is from the neighbouring districts.

### **Hospital infrastructure**

The ward facilities consist of 6 blocks of cells, 3 pavilion wards, 3 blocks of halls. There are closed wards, open wards, paying wards, family wards and chronic



wards. The family wards where family members could stay with the patients were introduced in 1984. Minimal extra facilities have been provided like attached bathrooms. The total bed strength is 361 and there has been no overcrowding. Occasionally children with psychiatric disorders are admitted to the family wards with their parents. Buildings are maintained by the PWD. The cells are maintained in a bad state. The pavilion and closed wards are better. Maintenance and repairs by the PWD is erratic. Funds for maintenance is reportedly insufficient. Some of the cells have been renovated.

### **Staffing pattern**

This Centre is governed by the Directorate of Health Services, Thiruvananthapuram and headed by a Superintendent who is a qualified psychiatrist. There are 8 other Medical Officers, currently working along with him. There are 7 Psychiatrists, 1 General Medical Officer, 1 Clinical Psychologist, 1 Psychiatric Social Worker, 35 general and psychiatric nurses, 2 Instructors, 1 Radiology technician, 10 Administrative staff, 23 ward attenders, 38 nursing aids, 1 Medical Records Officer and 1 Dietician. There is a lay-secretary cum treasurer as Head of the office administration. Resident Medical Officer is supposed to stay on campus. The staffing appears to be adequate compared to the other hospitals in Kerala. The staff is paid as per the State Government pay structures. Working hours of the doctors is from 8 a.m. to 1 p.m. However, it was noticed that the effective working hours are from 9 a.m. to 12 Noon. Office staff work from 10 a.m. to 1 p.m. and 2 p.m. to 5 p.m. Service conditions are reasonable.

### **Admission and discharge**

The voluntary admissions are on petition by relatives. Involuntary and criminal patients are admitted by court orders. Admitting authorities are psychiatrists and judiciary. Police assistance is available for the patients from jails. Admissions and discharges are governed by Mental Health Act, 1987. Discharges are made on request from the patient or his relatives. The other modes of discharge are by the Board of Visitors or through the order of magistrates. Rights of the patients are reportedly explained to them at the time of admission. However, on enquiry, this was not substantiated. Suicides and escapes of patients are negligible. The majority of patients in the ward have stayed here for less than 2 years. People who are staying for more than 5 years are few. The average duration of stay is 6 - 12 weeks. Repeat admissions are quite common, as family members are not tolerant. Some efforts are being made to discharge long stay patients through the District Collector and Social Agencies. Patients have a right to appeal if they have any grievances. There is a need for having more social workers to work with families and facilitate discharge. The annual budget for the hospital is inadequate. This hospital receives small amounts of donation in cash and kind.



## **SERVICES**

### **Casualty and emergency service**

Emergency services are available in the outpatient. The casualty works from 8 p.m. to 8 a.m. The majority of patients are admitted to the observation ward attached to the OPD. About 95% of the cases are admitted after observation and only 5% are sent home. Quality of equipment in the casualty is average and the facilities are just about adequate. Ambulance facility is present but only until 5 p.m. as there is only one driver, but it is also available on holidays. The ambulance is in good condition.

### **Outpatient service**

The hospital runs an outpatient service. Psychiatrists are posted to the outpatient services. Adequate time is spent with the patients in the outpatient. Free drugs are not available to any patient in the outpatient. However, free drugs are available for inpatients. No registration fee is charged by this hospital for any outpatient service.

### **Inpatient service**

Cell wards and single rooms with iron gates are present and are used regularly. The negative feature that mars this otherwise average hospital is the presence of cells where overcrowding is present, and patients are not provided with adequate clothing or any basic facility. In the cells patients are stripped down to their underclothes on account of fear of potential suicide. Earlier governmental and police enquiries and harassment of doctors when suicides or escapes occurred has made the doctors extremely nervous about such measures. Even the newer wards that are constructed have iron bars and gates.

The rest of the wards are fairly adequate and not crowded. Inpatient activities are present but not very structured. Wards are generally in good condition; cleaned daily and dresses of patients are changed daily. Cot, mattress, linen and pillows are available for every patient except in the cells. Patients are allowed to wash their own dresses. Adequate basic facilities like toilets and fans are present in the wards. There is no facility for keeping the belongings. There are no chairs. Privacy for patients in the wards is poor. Recreational facilities like radio, T.V., indoor and outdoor games are provided for the patients. The ward staff maintains records of menstruation, body weight and other vital parameters. This hospital does not shave the heads of the patients for lice infestation. Anti-lice, anti mosquito measures are present predominantly using chemical repellents. Only 2% of the patients are paying patients and 98% are non-paying. The visiting hours for relatives is from 10 a.m. to 1 p.m. and 3 - 5 p.m. Telephone and intercom network connects the wards. No



electricity generator facility is available. All the drains are of closed type and adequate water supply available in the campus. The library for the patients is predominantly in the vernacular language. Books are also available in the library.

The budgetary allocation for food seems to be adequate at the rate of Rs. 25/- per patient. Quality of food is checked by the Resident Medical officer. However, patients complain about the poor quality of the cooked food supply as well as service. Patients get adequate amount of food. Closed containers are used for carrying the food. Gas cooking or wood is used for cooking. Food is served in plates near the bed. A unique feature is the way in which food waste is disposed as feed for the piggery and poultry. Drinking water facilities are provided through open taps. There is no water filter or water cooler.

The treatment of patients is better compared to other hospitals in Kerala. Drug therapy and modified ECTs are provided. Patients occasionally have the benefit of psychotherapy and rehabilitation. Routine blood investigations and x-ray are available. Advanced investigations are not available. Specialised medical consultations are made to the nearby government hospitals. There are separate case files for each patient but records are very inadequate. Only 5% of the case files are non-retrievable. Most of the information in the files is kept confidential.

Separate rehabilitation facilities are absent. However, patients are involved in occupational therapy like cultivation, piggery, planting, nursery and running a stationery shop. There is no separate rehabilitation ward only a few occupational therapy programmes are available for the inpatients (only 40 out of 361 patients attend the rehabilitation program). Most of the placements and jobs are inside the hospital. All the patients are provided incentives. Behavioural modification is used in the area of rehabilitation. No follow-up assessments are made. Difference of opinion among the senior staff members and has prevented smooth running of rehabilitation activities.

Participation by lay volunteers is encouraged. Agencies like horticultural society, NSS units, students and staff from local colleges are involved. The staff deputed for rehabilitation work is inadequate. The Medical Superintendent admits that there are difficulties for rehabilitation programs as there are insufficient workers. Staff members are generally motivated. There are staff meetings and some in-service training programs at present. Very few nurses have training in psychiatric nursing.

### **Rights and legal aspects**

Even though it is mentioned that the rights of the patients are very well informed. This is not true. The staff members are not fully aware or sensitive to the rights of the mentally ill. However, patients are allowed to talk to social agency



personnel. They are allowed to write letters to their houses. They are sent home on leaves of absence (parole). There is a Board of Visitors from 1993 which has been functioning as per the Mental Health Act, 1987. The Board of Visitors is constituted by a government order and consists of official and non-official members. Percentage of all admissions through legal procedures is 19%. The hospital has complied with the Mental Health Act, 1987 partially as the State Government has not issued the government order with regard to the rules of Mental Health Act. There are some court representations (public interest and other cases) and the High Court of Kerala is giving directions regarding the functioning of the institution since 1997.

## **Summary**

This is the only government hospital in Kerala where the quality of care is average. The hospital is headed by a medical superintendent (psychiatrist) supported by a team of psychiatrists and adequate staff. They have managed to avoid overcrowding and restricted bed strength to the sanctioned number. The Mental Health Act is complied with. There is a semblance of standard psychiatric practice with occupational therapy and other psychosocial therapies. The wards and facilities are fairly clean and the amenities and supportive services are adequate. The staff has better morale and feels they can make changes. The only dark area is the use of cells that are overcrowded and without facilities. To add insult to this indignity the patients are stripped of their clothes for fear of suicide. The role of the government officials together with the mistaken attitudes of the mental health professionals are responsible for these anomalies. It is worth looking at the factors which cause this discrepancy within the same hospital and hospitals across this State.

## **Suggestions for the State**

The government and hospital officials have to immediately act for implementation of suggestions for improvement of the three hospitals. There is at present a welcome development, the appointment by the High Court of a monitoring committee to look into the functioning of all the mental hospitals of the State. The committee has suggested many changes and they are being implemented. However, functional improvement in terms of treatment techniques and provision of non-medical mental health professionals and their services are not present. It is a well-known fact that along with the medical management, techniques of psychosocial treatment have been found to be very effective in improving the outcome of mental illness. It is sad to note that the state, which leads in other health indices, is so backward and insensitive to the plight of the mentally ill. This issue needs to be addressed as a priority. Interestingly, some of the present teams of doctors, nurses and ward staff in these hospitals are quite enthusiastic and have many ideas and suggestions for improvements, which are quite noteworthy. These motivated staff must be involved to bring about these changes.



- Mental Health Act, 1987 must be implemented immediately and in full.
- The Medical Superintendent must be a psychiatrist and head the hospital. He must be given more autonomy.
- Admission and discharges must follow the Act strictly. External influences for admission and discharges must be stopped.
- Daily Outpatient and Emergency services with interview rooms, waiting hall, medical records, short stay wards and adequate staff must be ensured.
- Standard psychiatric care in terms of recommended drugs, modified ECT and psychosocial treatments in wards and OPD must be followed.
- Better lab facilities for essential investigations in the OPD and inpatient services should be provided.
- Cell admissions in all hospitals must be abolished immediately.
- Discharge after recovery must be hastened and duration of hospitalisation minimised.
- Overcrowding must be by restricted and patient strength reduced to the sanctioned number.
- Admissions to open wards with a family member must be encouraged. Closed ward admissions must be avoided.
- Smaller wards (10-20bed units) with recommended number of staff nurses and ward attenders dedicated to each ward must be created.
- Patients must be seen regularly by a multi-disciplinary team of doctors and other professionals.
- Recommended changes in infrastructure in terms of wards and adjoining facilities must be made.
- Amenities like adequate food, medicines, clothing, drinking water, cots, linen, and other necessities must be provided.
- Regular water and electricity supply, drainage and communications network (telephones and intercom) must be ensured.
- Adequate support services like kitchen, laundry, pharmacy, stores, and maintenance should be ensured.
- Separate wards for medico-legal patients, medical emergencies, alcohol and drug dependence and children should be set up.
- Recreational facilities attached to every ward must be created.
- Proper rehabilitation facilities including day care centre must be set up.



- Staff pattern with recommended psychiatrists, psychiatric nurses, psychiatric social workers, clinical psychologists, occupational therapists, instructors, and ward attenders must be improved.
- Regular in-service training for all staff members must be provided.
- Board of Visitors to act as inspection/monitoring authority for each hospital must be constituted.
- These hospitals must be made into teaching hospitals with postgraduate students posted in the wards.
- Relatives, public and staff members must be educated about mental illness to remove the stigma and for acceptance in the community.



# CHAPTER-24

## MAHARASHTRA

### INTRODUCTION

At the time of Independence the state of Bombay comprised of Maharashtra and Gujarat. Maharashtra emerged as a separate state on May 1<sup>st</sup>, 1960 under the Bombay Reorganisation Act. It is the third largest state in India, both in area and population. It covers an area of 307,690 sq. km and has a population of approximately 79 million. The density of the population is 256 persons per sq. km. It has a sex ratio of 936 females for 1000 males and about 39% of the population is urban based. The literacy rate is 63% being higher for males (75%) than for females (50%).

Maharashtra forms a huge irregular triangle with its base on the West Coast of India overlooking the Arabian sea. It is traditionally divided into 3 regions: Western Maharashtra, Vidarbha and Marathwada. The state is divided into 31 districts with the capital at Mumbai. There are four mental hospitals, 2 serving the western region (Thane and Ratnagiri), one in the Vidarbha region (Nagpur) and one in the Marathwada area (Pune). The hospital in Yeravada, Pune is the largest not only in India, but also in Asia. In addition, there are a number of government and private medical colleges with psychiatry units and private practitioners in the major cities.

### REGIONAL MENTAL HOSPITAL, THANE

#### Background

The Regional Mental Hospital at Thane was established in 1901. A philanthropist named H. Narottamdas donated a sum of Rs. 30,000 to the Government in the name of his mother Smt. Putlibai for the Naupada Mental Hospital (now Thane). The interest generated was to be used to improve the quality of food, clothing and medical care. In addition, it was felt that providing activities of amusement and recreation would alleviate, and even cure, the suffering of the mentally ill. The first superintendent post-independence was Dr. S.K. Phadke. The present medical superintendent, Dr. P.T. Lavatre is a senior psychiatrist. The bed strength of the hospital is 1880 with 800 beds for females.

The hospital is located close to the Thane railway station. Initially it was considered as an isolated area where people were afraid to walk. However, increasing urban expansion has resulted in schools, colleges, residential apartments and commercial complexes coming up in the immediate neighbourhood.



## **Infrastructure**

The hospital is a complex of several tiled roof buildings spread over 45 acres of land. It is surrounded by a high jail like wall with barbed wire on the top. Many of the old structures are unfit for use. Some of the buildings still in use are in poor condition with problems aggravated in the monsoon season. They require frequent repairs and maintenance work. One feature of this hospital is the presence of a unit of the PWD in the hospital. This has resulted in their being responsive to the needs of the hospital. However, a new building is urgently required and the old structures can be demolished in a phased manner.

All wards are closed. There are no open or special wards. There are separate wards for criminal and undertrial patients, patients with epilepsy, Hansen's disease and the medically ill. The wards vary in size housing between 35 to 50+ in each. Many of the wards are overcrowded.

About 50% of the patients have adequate cots and bedding. Many patients sleep on the floor and the fact that there is not enough space raises the possibility of physical and/or sexual abuse. Wards have adequate ventilation and electrical supply. Fans are adequate in number, but the existing lighting is not sufficient. Each ward has about 2 toilets, which is insufficient for the size of the ward. Although some degree of privacy is present, other amenities such as running water, bucket or mug is absent. Solar heating has been installed for hot water for bathing but, especially on the male side, there is not enough privacy. Mirrors are there in some of the wards on the female side. Individual lockers for personal belongings are not provided.

## **Staff pattern**

The medical superintendent is the overall in-charge. He is assisted by 9 psychiatrists, 7 psychiatric/medical social workers and 16 trained psychiatric nurses. In addition, there are 9 medical officers, including an anesthetist, and 61 nurses. There are 5 occupational therapists, 2 laboratory technicians, 30 administrative staff and about 312 group D staff. There are at present no clinical psychologists with 2 posts lying vacant. Psychology students in the Master's program come for block placement to the hospital and provide the psychological testing services. Thirty beds have been allocated to a private teaching medical college and are looked after by a psychiatrist and students from that college.

The number of mental health professionals is far less in comparison to the bed strength.

However, a positive feature is that many of the trained psychiatric nurses were in-service candidates who were deputed for training to NIMHANS, Bangalore. They



have been able to make a significant contribution in improving the routine in-patient care. One of the difficulties experienced by the nursing staff is that the entire group D cadre does not come under their supervision. While the matron supervises the female attendants, the male attendants come under the jurisdiction of the overseer. This often causes friction and results in lack of coordination in implementing ward activities. Moreover, the overseers are usually active union leaders and wield considerable power over their subordinates. This anomaly needs to be rectified so that the nursing matron is the supervisor for all the nurses and group D staff.

Meetings of the staff are held once in a month. The staff burnout is quite high especially at the group D level. Many of the group D staff have been identified as difficult to handle in other departments and posted to the mental hospital as a punishment transfer. These few persons are often successful in disrupting the work ethos of others around them. The lack of promotional avenues, inadequate exposure to newer developments in the field and large number of chronic patients are stated as reasons for burnout.

### **Admission and discharge**

All admissions are governed by the Mental Health Act, 1987 with the admitting authority being the psychiatrist, police and judiciary. However, voluntary admissions are still very low forming barely 10% of the total admissions. The current occupancy is about 85% with a total of 1601 patients. About 26% (N=416) of the patients are long stay having been in the hospital for a period of 5 years or more. The average duration of stay is about 3 months. There has been one suicide in the past five years and no homicides. There are about 7 to 8 escapes per year. The death rate in the hospital has been about 6 % (N=105) per year. This could be because of two factors: one, with the number of long stay patients there is an aging population and secondly, the facility for medical emergencies is rather poor.

Decertification is done by the board of visitors and patients discharged with their relatives. Male patients are sent alone and females with hospital escort. Discharge problems are mainly due to inadequate family support, families living far away from the hospital without adequate emergency care close by and readmission perceived as being difficult. Almost 40% of the cases are readmitted and this is largely due to drug default or inability to adjust to the home environment. Patients are informed of their rights on admission and can represent their grievances to the board of visitors through the staff.

### **Finance**

The current plan budget is about 16 lakhs and the non-plan budget is about 493 lakhs.



The non-plan budget has increased by about 54% in the last five years. The major part of the expenditure is on staff salaries, followed by food, drugs and linen. The budget allocation is perceived as adequate for the existing services. Donations have been received both in cash and in kind such as television sets and wall clocks. Sponsors also come forward to support cultural and recreational programmes in the hospital.

## **SERVICES**

### **Casualty and emergency service**

The hospital does not have a casualty and emergency service. There is no short stay ward. There is one ambulance in roadworthy condition. Excited patients are admitted directly by the duty doctor. In-patients with medical emergencies are transferred in the ambulance to the general hospital with a nurse or attendant.

### **Outpatient service**

Daily outpatient services are run from 8.30 am to 1pm. There is a waiting hall which can seat about 25 to 30 people comfortably and 2 rooms for interviewing the patient.

The case is registered by a clerical staff, worked up by a social worker and then discussed with the psychiatrist. Charge for registration is nominal being Rs. 4/- for new cases and RS/- 2 for old. About 60 patients are seen every day, with about 6 new cases per day. On an average, 15 to 20 patients are brought in an excited condition and 3 to 4 of them may be brought tied with ropes.

The outpatient service is run with the existing staff on rotation basis. The average time spent is 5 minutes for a follow-up and about 15 minutes with a new case. This results in the intervention being mainly medical ( Pharmacotherapy and ECT's) and there is not enough time to enter adequate follow up notes. Charges are on the basis of income with Rs. 40/- being the maximum for one month's supply of medication. The majority (50-75%) get free drugs. The supply of medication is good with newer drugs also in stock. Record keeping is good and confidentiality is adequate.

There is a need for a new outpatient building and this should be located closer to the main entrance of the hospital to be more accessible.

### **Inpatient service**

Overall the inpatient facilities are inadequate because of the current living arrangements. The male wards are in marginally better condition than the female wards.



There is one observation ward ( male) and the rest are all chronic wards. Recovered patients are kept along with symptomatic patients. Wards are cleaned daily and the linen changed twice a week. Patients have a bath every day and a fresh set of clothing provided twice a week. All patients are made to wear hospital uniform in order to facilitate identification in case of escape. A few recovered patients who help the nursing and attendant staff are provided with saris or pajamas. Patients, especially females, complained that the bathing facilities are not adequate. There is not enough running water and the supply of toiletries such as soap and oil is not sufficient. They felt that the hospital clothes were dehumanizing and not changed as frequently as they would like.

Services of a barber are available. For male patients, face shaving is done weekly and head shaving carried out once a month; for female patients it is done when delousing measures are inadequate. Anti mosquito measures in the wards are in the form of wire mesh and use of chemical repellents. In addition, staff from the malaria eradication programme come and spray the drains and compound.

The kitchen is housed in a separate building. It is well lit and ventilated. Food is prepared hygienically and cooked on gas. Female patients help in the making of chapathies. Three meals plus tea amounting to about 2700 calories at a cost of Rs.16/- per day are served for each individual. A staff member checks the cooked food every day before it is distributed. Patients carry the food in closed steel containers to the wards. The food is served on steel plates and patients sit on the floor either in the verandah inside the ward or, weather permitting, on a cemented area outside the ward. Drinking water is available in the wards. Although the quantity of food may be adequate, it is not sufficient in terms of nutritive value. Many of the patients are on vitamin and iron supplements. Seasonal fruits can be added to the diet.

Basic laboratory investigations such as routine blood and urine examination are done. There is a central sterilizing facility ( auto-clave) and radiographic equipment for x-rays. Psychology students posted here for training carry out the psychological testing.

Management is mainly medical with the use of drugs and modified ECT's. Violent and excited patients are also put in isolation cells and they sometimes injure themselves. There is hardly any psychosocial intervention. Family members are not permitted to see the patient in the ward, but can meet them in a visitor's room. Patients complained of not being able to contact their family members and expressed a wish to do so by phone or by writing letters. Arrangements for the same are inadequate.

Recreational facilities are present in the form of television, music, indoor games



and some magazines and newspapers. There is a temple in the campus. Staff and patients together celebrate various national and religious festivals. The hospital has been winning the first prize for its stall during the Ganesh Puja festivities. Occupational therapy is carried out with activities such as screen-printing, weaving, carpentry and tailoring. The number of patients utilizing these facilities is very low being largely limited to those who have recovered from the illness. No special inputs are made for the large number of chronic patients. The occupational therapists have had no training in dealing with psychiatric conditions. The lack of a clinical psychologist for developing intervention modules is acutely felt.

The medical facilities in the male and female infirmaries are inadequate. Medical emergencies are especially difficult to handle when they occur in the evening or night. There is one doctor on duty and one male and female nurse in the two infirmaries. The internal phones are not in working condition. If a patient gets excited or violent or has a medical emergency, the attender has to leave the ward and go personally to call the nurse or doctor. Since the campus is spread out over a large ground this results in a lot of unwarranted delay often leading to fatal complications.

### **Community service**

Training programmes for medical officers, multi-purpose workers and nurses have been carried out. Satellite services were being run at Jalgaon. Alibaug and Dhulia once a month, but have been discontinued because of lack of funds and adequate staff. Services of a psychiatrist are provided to the Beggars Home.

### **Legal aspects**

The board of visitors has been constituted and comprises of a District Session's Judge, a psychiatric social worker, the Superintendent of the Jail etc. The frequency of meetings is about once a month. There is no public interest litigation filed against this hospital.

### **SUGGESTIONS**

- New building with all facilities for better outpatient and inpatients services is urgently needed.
- The number of involuntary admissions has to be brought down to the minimum. Short stay wards and open wards to be started. Contact between the patient and family to be encouraged and strengthened.
- Posts of clinical psychologists to be filled up. Services of a clinical psychologist to be used not just for testing purpose, but in developing modules of intervention using cognitive, behavioural and psychological principles.



ples. Till the vacancies are filled, services of a clinical psychologist can be obtained on contract or visiting consultancy basis.

- Beds to be divided into functional units with a psychiatrist in charge.
- Recovered persons to be housed separately from the chronic patients.
- Active efforts to be made by the social workers to contact family members, educate them about the illness and help recovered patients to go back home.
- Psychosocial intervention including psychoeducation and individual and family counselling to be provided as a routine service.
- Psychosocial rehabilitation needs to be planned in a more structured manner from ward based activities that emphasize daily living skills to pre-vocational and vocational activities that enable the patient to develop a work habit. Occupational therapists can be deputed for training so as to be able to deal effectively with the psychiatrically ill.
- Staff need to be sensitized about the rights of the mentally ill.

## **REGIONAL MENTAL HOSPITAL, YERAVDA, PUNE**

### **Background**

The Regional Mental Hospital at Yeravda, Pune was established in 1907 and initially located in Colaba, Bombay. It had about 700 beds and was meant for British soldiers and citizens of the British Empire from the Far East. An army officer with the help of a few doctors and nurses ran it. The entire hospital - patients, staff and material were shifted to the present location in Yeravda, Pune by a special train in 1915. Over the years the bed strength increased to 1200, then 1700 and is currently at 2540. The first Indian superintendent was Dr. G.A. Bhagwat who took over in 1947. The current superintendent is not a psychiatrist. However, the deputy medical superintendent, Dr. S. Ramamurti, is a psychiatrist.

The hospital used to be on the outskirts of the city but with urban expansion the area is no longer considered isolated. It is situated next to the Yeravada jail, which is well known because Mahatma Gandhi was a prisoner here during the freedom struggle. A drug deaddiction centre, the first in the state of Maharashtra, was established in the same campus in 1985. It is currently an autonomous institution.

### **Infrastructure**

The hospital comprises of largely single storey barrack like structures spread over an area of 50 acres. There are 4 double storied structures. There are plans to



build new dormitory like blocks. A high prison wall with high gates surrounds the hospital. All wards are closed. There are 2 paying or special wards. There is a separate ward for criminal patients, for weak and physically ill patients (mainly mental retardation with epilepsy) and a male and female infirmary. There is a ward for male children and female children are kept with the adult female patients. At present, there are about 24 children ranging in age from 7 years to 14 years in the hospital. Many of the tiled roofs have been replaced by asbestos. Some of the wards are just large halls housing about 125 patients. These look more like cattle sheds than hospital wards.

The number of cots is inadequate with a ratio of 1:5. Many patients prefer to sleep on the floor and are provided with dhurries. Electricity and water supply are erratic and there are plans to have a separate sub-station and a separate water supply line for the hospital. The existing toilets, fans and lighting arrangements are not adequate. Facility for keeping patient's belongings in the ward is present in some of the wards. Solar heating has been installed at a cost of 24 lakhs in order to provide hot water for bathing.

### **Staff pattern**

The Medical Superintendent who is the overall in-charge is not a psychiatrist. A deputy medical superintendent is a psychiatrist and looks after the day to day running of the hospital. There are 13 psychiatrists, 5 psychiatric/medical social workers and 21 psychiatric nurses. All the 3 posts of clinical psychologists and an additional 3 posts of psychiatric social workers are currently vacant. In addition, there are 18 medical officers, 75 nurses and 5 occupational therapists. Three posts of occupational therapists are vacant. Administrative staff consists of 33 persons and there are 4 laboratory technicians and 747 group D staff. Two posts of visiting consultants, that of a general physician and dentist, are vacant. The staff-patient ratio is inadequate considering the bed strength of the hospital.

The working hours are 9am to 2pm for the psychiatrists and medical officers with one person on duty between 1pm to 6pm. For all the others, working hours is from 10am to 5.45 p.m. The Deputy Medical Superintendent is a dynamic and committed person who often gets frustrated with the magnitude of the problems and the resistance to change. The level of burnout among staff is reported as about 10%, but actually appears higher, being particularly so amongst the group D workers. Many of the medical personnel are engaged in private practice and not too involved in the clinical services. However, there are exceptions. For e.g. the forensic psychiatrist in charge of the criminal ward has streamlined a lot of the paper work required in relation to routine legal procedures and the medical officer in charge of the infirmary has ensured that exacting standards of cleanliness and hygiene are adhered to by the staff. The standard practice of universal precaution for handling of



blood products is being followed here.

Despite the shortage of hands, the nursing staff are doing their best to provide better care. The main difficulty reported is that the male attenders are not accountable to the nursing supervisor. This administrative problem has been highlighted with regard to the Thane hospital. The group D staff have 2 strong unions and are often in confrontation with each other.

### **Admission and discharge**

All admissions are governed by the Mental Health Act, 1987, and the Indian Lunacy Act 1912. The admitting authorities are the psychiatrist, police and the judiciary. Voluntary admissions constitute about 27% of the total admissions. Many of the admissions are made under the involuntary category in order to avail of free treatment. Many a time, the relatives cannot afford to lose their daily wage and are therefore unable to accompany the patient. Since admission procedures have not been simplified, most of the cases are not discharged but shown as being on 'leave of absence'. About 10% of the cases are admitted on the basis of payment.

The current occupancy is about 95% (N=2411). About 44% (N=1066) of the patients are long stay patients having been in the hospital for more than 5 years. The average duration of stay is about 2 months. There have been no incidents of suicide or homicide in the past five years, but the average number of escapes is 35 per year. Deaths in the hospital are about 8% (200) per year. This is mainly due to the number of long stay patients who, as they age, need more physical/medical care.

The board of visitors does the decertification. Female patients are sent home with their relatives or with hospital escort and male patients are sent on their own. Discharge problems are mainly due to inadequate family support and perceived difficulty in readmitting the patient. About 34% of the cases are readmitted, relapse of illness is usually due to drug default and inability to adjust to the family environment. The absence of psychiatric facilities at the district level makes the patient and family dependent on the hospital.

### **Finance**

There has been a steady increase in both the plan and non-plan budget in the past five years. Currently, the plan budget is about 64 lakhs and the non-plan budget is about 664 lakhs. Seventy two percent (72%) of the funds are spent on salaries, and the remaining on food (17%), drugs (4%) maintenance and linen (3%). The budget allocation is perceived as inadequate. Donations have been received in cash and in kind. The latter have been in the form of television sets and fans for the wards.



## **SERVICES**

### **Casualty and emergency service**

There are no casualty or emergency services. Excited or violent patients are admitted directly. There is a duty doctor's room which is adequately equipped. There is one roadworthy ambulance. Medical emergencies in the hospital have to be transferred to the Sassoon General Hospital. The staff expressed that this arrangement was not at all satisfactory as they have a large number of physically ill patients.

### **Outpatient service**

Outpatient services are run every day from 9am to 2 p.m. There is a waiting hall, which can seat about 15 people and 2 interview rooms. The services are run with the existing staff. About 60 patients are seen per day, with 1 or 2 cases being brought in chains by the police or tied with ropes by relatives. The average waiting time is about 30 minutes to an hour with 10 minutes being spent with each patient. A nominal registration fee of Rs. 2/- is charged per visit. Free medication is given for one month at a time. Basic drugs are available, some of the newer drugs are not supplied. Not much time is spent on individual or family counselling. Some educational material on mental health and illness sponsored by a pharmaceutical company is available. Records are well maintained and easily retrieved. Confidentiality of files is adequate.

Although the outpatient building was built fairly recently it has not been constructed with adequate planning for expansion. The administrative and clinical staff occupies a major portion of the building. The outpatient looks crowded with not enough seating arrangement.

### **Inpatient service**

The large and unwieldy size of the hospital, the lack of adequate trained staff and the poor infrastructure makes the inpatient facilities far from desirable. There are no separate wards for patients in the acute and chronic phase of the illness. A number of patients in the 'weak' wards have mental retardation with epilepsy and need a lot of nursing care and assistance in activities of daily living. Thirty five patients are on anti-tuberculosis treatment and have been segregated.

The wards are cleaned every day and linen changed twice a week. Patients can have a bath every day and provided with a dress change twice a week. Although patients are permitted to wear their own clothes, in practice, this is seen only in the special wards.

Recovered patients are given saris or shirts and pajamas. Services of a barber



are available, once a month for haircuts and twice a week for face shaving. Head shaving is not done routinely. Delousing procedures are routinely used. Anti mosquito precautions are taken, but not adequate since there is a lot of marshy, open area.

The kitchen is located in a separate building. Cooking is done on gas and firewood, and the food checked by the dietician or medical officer. Since the quantity of provisions and vegetables required is large it is not stored. Annual contracts are given for daily supply. This has to be carefully monitored since there is scope for corrupt practice. Due to several complaints about the quality of food, the Deputy Medical Superintendent has been personally checking the supplies. Recently, for e.g. the entire consignment of bread supplied from the bakery in the jail had to be returned as it was stale with fungal growth. Samples of the provisions are also subjected to random checks and sent to the laboratory for analysis. The kitchen needs to be modernised for more efficient cooking. Three meals a day plus 2 teas, varying between 2200 to 2900 are provided at a cost of Rs. 17/- per head. The food is carried in closed containers by patients or pulled in trolleys. In the paying wards the meals are served in a dining hall. In the general wards, patients sit on the floor of the verandah or, weather permitting, sit outside and eat their food. Old aluminum plates and glasses are gradually being replaced by stainless steel.

Basic laboratory investigations including routine blood and urine examination, Lithium estimation, and screening for VDRL and Hepatitis B are available. In fact, anti venom for snakebites are kept ready after one or two instances of snakebite were reported. EEG recording and radiographic equipment for X-rays are present. All investigations are done free of charge. Psychological testing is reported as available, but it is not clear as to how these are being done in the absence of a clinical psychologist.

Pharmacotherapy is the mainstay of treatment with both direct and modified ECT's being used when indicated. In addition, physical restraint and isolation may be used to bring excited or violent patients under control. Psychosocial and behavioural interventions are reported as present, but in actual practice is limited to very basic psychoeducation.

There are a large number of chronic patients with negative symptoms and self-stimulatory behaviour such as rocking who require more specific and targeted intervention programmes.

Recreational facilities in the ward such as television, radio, music, indoor and outdoor games and some reading material are present. Occupational therapy is present and the activities available are carpentry, tailoring, weaving, screen-printing, embroidery and crafts and a section where coir mattresses are made. The number of patients attending these facilities is however, small. The occupational therapist are



not oriented to dealing with the mentally ill and are functioning more as supervisors of work activity rather than providing specialized inputs.

There are no open or family wards where the family member can stay with the patient. Family members are allowed to visit the patient in the ward. A ledger is maintained at the gates to record these visits. More active and focussed psychosocial intervention is required in order to educate the families and involve them as partners in care.

## **Community service**

At present involvement of NGO's and other voluntary organisations is not very active.

This is a community resource that needs to be explored and utilised.

The staff at the RMH, Yeravada have been involved in a number of community based extension programmes. Initially they were providing satellite services to eight different taluks. Local PHC doctors were then trained to run these services. In some of the centers, posts of psychiatrist were also created under the district mental health programme. These clinics were well attended. However, transfer of trained medical officers and non-availability of medication has resulted in many of these services being discontinued.

A number of training programs have been conducted for different levels of staff such as medical officers, nurses, multi-purpose workers, psychology and social work students and the police personnel.

## **Legal aspects**

The board of visitors has been constituted as per the Mental Health Act 1987. The District Session's Judge, 2 social workers and the Jail Superintendent, among others, are members of this board. The board meets on the 1st Thursday of every month. Patients are informed of their rights and can make representations to the board. Many of the improvements in this hospital came as a result of public interest litigation and a contempt of court order that was issued for not carrying out the order. However, much still remains to be done. One area of concern is the fact that 24 children are institutionalised here with no special care or inputs. This is a certain violation of their basic rights and needs to be attended to immediately.

## **SUGGESTIONS**

- 1 A master plan for downsizing of the hospital needs to be drawn up. Although the number of professional staff has to be increased, it would not be advisable to create posts for a 2500 bed hospital. Instead, the reorgani-



zation should lead to more functional and manageable units. This has to be done in a phased manner and cater to the needs of different categories of patients.

- Admission procedures need to be simplified and the majority of admissions should be under the voluntary category.
- Open and family wards should be started. Psychoeducation and psychosocial intervention should form a part of the routine care.
- Keeping children in the mental hospital with adult patients is in violation of the Mental Health Act 1987. The children should be immediately transferred to a more conducive environment or provided a separate facility with special inputs in child and adolescent psychiatry.
- One or two clinical psychologists to be appointed immediately. Contract basis or visiting consultancy can be considered in the interim period.
- Occupational therapy and psychosocial rehabilitation inputs to be made more structured and strengthened so as to benefit a larger number of patients. Motivated occupational therapists can be deputed for training in psychiatric aspects to NIMHANS, Bangalore.
- Day care centre and sheltered workshops to be started, preferably with support and participation of local NGO's or voluntary bodies.
- Horticulture and floriculture activities can be started as part of occupational therapy activities on the premises. This will also help in better maintenance of the premises.
- Academic programs such as attending workshops and seminars and socio-cultural activities to increase the interaction amongst the staff to reduce burnout.

## **REGIONAL MENTAL HOSPITAL, NAGPUR**

### **Background**

The Regional Mental Hospital at Nagpur was established in 1864 at Jabalpur, Madhya Pradesh. It was shifted to Nagpur in 1904, then under the central province. In 1988, the name was changed to Institute of Mental Health. Being located close to the border, it caters to persons from the neighbouring states of Andhra Pradesh and Madhya Pradesh. The hospital has a bed strength of 910 of which 280 are for female patients.

Since the past five years the hospital has been experiencing administrative difficulties and has been functioning under a series of in-charge superintendents. Re-



cently, two consecutive superintendents, along with an administrative officer and an overseer, were placed under suspension for administrative lapses and subsequently, their services were terminated. Even today, the post is vacant and the district civil surgeon, Dr. P.R.Singh is the acting superintendent. The deputy director health services of the Government of Maharashtra has also been entrusted with the task of overseeing the functioning of the Institute.

The hospital is centrally located and situated close to bus and rail transport services.

It is spread over a large campus of 160 acres. An additional 150 acres of land has been given to the Central Government for the National Academy of Direct Taxes.

### **Infrastructure**

The hospital has several individual buildings and a jail- like appearance as it is surrounded by high walls. There are no open wards. There are separate wards for chronic patients, for patients with epilepsy and for criminal patients. Recently a deaddiction facility with 30 beds has been started. The old cells have been converted into special rooms for individual occupation on the basis of payment. About 40% of the patients are in the paying category either as voluntary admissions or as per the order of the court. Unfortunately, the wards that have been built recently have not incorporated modern facilities. Instead large wards accommodating 50 people have been constructed. Some of the older structures are in need of constant repair and maintenance work and should actually be demolished to make way for new buildings. A unit of the PWD is posted in the hospital and this facilitates the repair work.

Electrical supply is adequate, and there is a generator in case of power failure. Water supply is erratic and an overhead tank has been sanctioned at the cost of 3.7 lakhs to overcome this problem. Although many of the cots are rusted, each patient has a cot and adequate bedding. Cots with low height have been provided for patients with epilepsy so as to prevent injury in case of fall. Fans and lights are present in the wards, but the amount of light generated is not enough for the large wards. Toilets do not have running water and amenities such as bucket and mug. Bathing facilities are inadequate with male patients having to bathe outside. Hot water is provided using firewood.

### **Staff pattern**

As mentioned in the introduction the Institute has been plagued by administrative difficulties. The in-charge Medical Superintendent and the Deputy Medical Superintendents are not psychiatrists. There is one psychiatrist, 9 medical officers, one clinical psychologist, 7 medical social workers, 25 psychiatric nurses and 60



nurses. There are 5 occupational therapists, 1 laboratory technician and 170 group D staff. About 110 staff stay on the campus which includes professional staff, nurses and attenders. The doctors' work from 8.30 to 2.30pm and the other staff an 8-hour shift. There are no visiting consultants.

Regular meetings of the staff are held and the nurses and attenders provided some in-service training. Although, no staff burnout is reported, in practice it is present especially among the nurses and the attenders. Overall, the staff position is inadequate in terms of mental health professionals. The number of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses need to be increased.

### **Admission and discharge**

All admissions are governed by the Mental Health Act 1987 with the admitting authority being the psychiatrist, police and the judiciary. Voluntary admissions form just 14% of the total admissions, with many still occurring through reception or detention order. The current occupancy rate is 79% (N= 722). About 46% (N=332) of the patients are long stay having been in the hospital for more than 5 years. The average duration of stay is a little over a month (40 days). There have been no suicides or homicides reported in the past five years. In this period, however, the average escapes are about 25 per year and the deaths are about 6% (42) per year. The latter is primarily because of an aging population among the chronic patients.

Decertification is done by the board of visitors and hospital authorities and patients sent home with relatives, or hospital escort and on their own in the case of male patients.

Discharge problems are mainly due to patients having significant disability and being perceived as a burden by the family. About 30% of the patients are readmitted, the most common reason being non-compliance with medication.

### **Finance**

The budget allocation has increased by 60% in the past five years and is currently about 299 lakhs. The major expenditure is on salaries (77%), with the rest being on food (14%), drugs (4%) and an average of 5% for linen. The budget allocation is perceived as adequate. Donations in terms of cash or kind have not been reported.

### **SERVICES**

#### **Casualty and emergency service**

There is no casualty or emergency service. Whenever required, patients are



admitted directly. Ambulance facility is not present. In case of medical emergency the hospital matador is used to transfer the patient to the general hospital.

## **Outpatient service**

Nagpur was the first mental hospital in Maharashtra to start the outpatient service in 1965. The outpatient runs every day from 8.30 am to 1.00pm. There is a waiting hall which can accommodate about 30% of the persons who come for follow-up. There are 3 interview rooms. The services are run with the existing staff on rotation basis. On an average, 60 new cases and 150 old cases are seen per day. About 8 to 10 patients are brought in an excited condition and about 1 or 2 per day may be tied. New cases are disposed off in 15 minutes and follow-up is done in about 3 to 5 minutes. Outpatient follow-up is maintained on slips. A nominal registration fee of Rs. 4/- is charged for new patients and RS.2/- for old. Free drugs for a period of one month are given to the majority of patients. Availability of drugs was adequate, however, newer drugs were not available. Prescriptions are still using polypharmacy and need to be improved.

In the outpatient, direct ECTs are administered. Due to the large numbers and the shortage of staff, psychoeducation or any other psychosocial input is not provided.

## **Inpatient service**

The inpatient services are inadequate mainly because of the current living arrangements. Wards are cleaned daily and the linen changed twice a week. Patients can have a bath daily and provided with a fresh set of clothing two times in a week. However, supply of towels and toiletries is inadequate. Patients are not permitted to wear their own clothing. Hospital clothing is used to maintain uniformity and easy identification in case of escape. Services of a barber are available and face shaving done weekly. Head shaving is done once a month for male and female patients. Anti-lice and anti-mosquito measures are routinely adopted.

The kitchen is housed in a separate building. It is well ventilated and has ceramic tiles for easy maintenance. Food is cooked on gas and checked by the medical officer on duty. As per the report, 3 meals a day plus tea amounting to 3200 calories per day at the rate of Rs. 10/- per head is provided. The price is subsidized because the patients in the hospital ground grow most of the vegetables. Quality and quantity of food is adequate. The cooked food is carried in closed containers and pushcarts to the wards by patients. It is served in plates and patients eat their meals seated on the verandah floor. Drinking water is available in all the wards and there are 5 water coolers. The hospital has considered giving the cooking arrangements on contract. However, this may not be desirable for a hospital since some patients may require special diets to be prescribed by a dietician. In fact, the hospital reports



about 40-45% of patients being on special diet.

Basic laboratory facilities are available including routine blood and urine examination, VDRL and Lithium estimation. Radiographic equipment has been purchased recently and an EEG machine purchased three years ago is currently not in working condition.

Psychological testing is done by the clinical psychologist and home visits by the social worker.

Pharmacotherapy is the main form of treatment and modified ECTs are administered for in-patients. Psychosocial intervention and behavioural techniques are used minimally.

Excited and violent patients are controlled primarily with medication and physical restraint. Recreational activities are available in the form of television, music and bhajans, indoor and out door games and some reading material. There is a temple in the hospital premises. Occupational therapy in tailoring, weaving, carpentry and gardening are provided. However, very few patients are availing the benefit of this treatment. The five occupational therapist are young and enthusiastic, but inexperienced in handling psychiatric patients. They need proper professional guidance and can be deputed for sensitisation to a center such as NIMHANS, Bangalore.

There are no open or family wards where the relative can stay with the patient. The campus has phone facility in the outpatient, but no canteen. Family members meet the patient in the visitors' room. This contact needs to be strengthened and reinforced more than is being done at present.

### **Community service**

College student volunteers, the local Lion's and Rotary club and other voluntary organizations are actively involved in the social and cultural activities arranged in the hospital for patients.

The staff is also running extension services at the district and taluk level. Several training programmes have been conducted for medical officers, nurses, multipurpose workers and for primary school teachers in the area of mental retardation.

### **Legal aspects**

The board of visitors has been constituted in compliance with the mental health act. It has the District Session's Judge, a psychiatric social worker and the jail superintendent as members. The board meets once a month. No public interest litigation has been filed against this hospital. However, the hospital staff needs to be sensitized about the rights of the mentally ill persons. At present the inadequate bathing



facilities, the mandatory shaving of head and the absence of adequate and effective psychosocial rehabilitation amount to a violation of basic rights of the mentally ill.

## **SUGGESTIONS**

- Psychiatrists must be immediately appointed to the posts of Medical Superintendent
- and Deputy Medical Superintendent .
- In order to provide quality care, the post of other mental health professionals, especially clinical psychologists and psychiatric social workers, should be filled and new posts created if necessary.
- Greater emphasis needs to be paid to staff issues such as inservice training, deputation for short-term training or workshops etc so as to reduce amotivation on the part of the staff.
- The hospital should be downsized in a phased manner. To facilitate this out patient facilities need to be improved. A short stay ward will help in early discharge of patients who do not need to be hospitalized for long periods.
- New wards constructed should be on modern principles. More wards should be open and provide for a relative to stay with the patient.
- Psychosocial rehabilitation facilities have to be strengthened in order to help patients return to the community, by starting a full fledged rehabilitation facility.
- Development of day care centre for chronic patients are necessary.

## **REGIONAL MENTAL HOSPITAL, RATNAGIRI**

### **Background**

The Regional Mental Hospital at Ratnagiri was established in 1886. It was built as a mental asylum for European patients with a bed strength of 365, with 65 being for female patients. Ratnagiri being situated in the Konkan coast has a salubrious climate.

It used to be a small town, better known for the famous Alphonso mangoes. Today, however, the town is witnessing a spiraling growth. Two factors have contributed to this: One is that Ratnagiri has become easily accessible with the opening of the Konkan railway. Secondly, a rather controversial, multinational power project is being constructed at Dabhol, a few kilometers away from Ratnagiri. The hospital is located at what used to be considered one end of the town. Today, it is the centre



of the city and the approach roads are wide and well maintained. The first Indian superintendent was Dr. Deo. The present medical superintendent is a young psychiatrist, Dr. K. Pavekar.

## **Infrastructure**

The hospital complex is comprised of several single storey buildings with tiled roofs.

The surrounding wall is moderately high. Most of the structures have stood the test of time and only a few are in need of repairs. The PWD unit posted in the hospital handles the maintenance. All the wards are closed. There are no special wards. There are separate wards for criminal patients and chronic patients and one ward each for patients with epilepsy and for patients with physical problems. Single cells for isolation are present.

The wards vary in size having between 15 to 20 patients. They are well ventilated and have adequate number of fans and light fixtures. Each patient has a cot to sleep on with adequate bedding. Although the number of toilets is adequate, they need to be improved. Running water is not always present and amenities like buckets and mugs need to be provided. In the toilets on the male side, a half wall has been built outside the toilets for greater privacy. The female toilets have curtains at the main entrance. Even the isolation cells have toilets. Water for bathing is heated using diesel stoves. Bathing areas can be further improved with tiles etc. There are mirrors in all the wards. Individual lockers for personal belongings are not provided. In the female wards, half curtains on the windows have been provided to ensure privacy.

## **Staff**

The medical superintendent is the overall in charge and the sole psychiatrist. He is assisted by four medical officers, one of whom is the Resident Medical Officer, 6 psychiatric nurses and 18 nurses. The posts of a clinical psychologist and social worker are currently vacant. There is one occupational therapist, one laboratory technician and a pharmacist, with 21 administrative staff and 145 group D staff. The Medical Superintendent felt that Ratnagiri, being a small town, in comparison to cities like Pune and Mumbai, is not considered as a desirable posting. There has been quite a turnover both at the professional and technician level, with the few who join, leaving after gaining some experience. Services of an anesthetist are available. The working hours for doctors is 8.30 a.m. to 2.30 p.m. and for the others it is an 8 hour shift.

Formal meetings of the staff are held once a month. However, the level of informal interaction is quite high, with the Medical Superintendent relating to col-



leagues and subordinates in a friendly manner. Even though he is young in age he is able to command the respect of his team. The nurses and group D staff have been sensitized to working with the mentally ill. In general, the level of involvement and commitment to work is high and burnout is low.

## **Admission and discharge**

All admissions are governed by the Mental Health Act 1987, with the admitting authority being the psychiatrist, police and judiciary. Voluntary admissions have gone up by 44% in the past five years and now comprise 79% of the total admissions. This is a very positive feature. About 40% of the voluntary admissions have to pay for the treatment and hospital stay. There are 218 persons hospitalized at present yielding an occupancy rate of about 60%. About 25% (N=54) of the patients are long stay having been in the hospital for five years or more. The average duration of stay is a little over a month (40 days). There have been no suicides, homicides and escapes reported in the last five years. There are about 10 deaths (2%) per year in hospital, primarily due to an aging population.

The board of visitors and the hospital authorities do the decertification. On discharge, patients are sent home with relatives, with hospital escort if female and on their own if male. Lack of adequate family support and inadequate recovery from the illness are the main reasons cited for discharge problems. About 30% of the patients are readmitted mainly due to poor drug compliance and inadequate follow-up.

## **Finance**

The current non-plan budget is about 117 lakhs. Special funds for improvement of the hospital were released in the years 1992 and 1993. The main expenditure is on salaries (74%), followed by food (14%), drugs (5%), miscellaneous (1%) and linen (2%). The budget is perceived as adequate for the existing services. Donations have been mainly in kind such as television sets, wall clocks, and sponsorship of cultural events.

## **SERVICES**

### **Casualty and emergency service**

The hospital does not have a casualty or emergency service. There is no short stay ward. The doctor on duty is called in the case of a psychiatric emergency that requires admission. There is a male medical ward with a glass screen separating it from the nurse's station. On the female side, the medically ill patients are managed in the nurses' duty room. However, in the event of an emergency the patient is sent



to the local general hospital in a hospital vehicle ( Trax or Matador), accompanied by a nurse or attendant. There is no ambulance facility.

## **Outpatient service**

Outpatient services are run every day from 8.30 a.m. to 1.00 p.m. with the existing staff. New cases, averaging 3 to 4 per day, are seen by the psychiatrist. On an average, about 20 to 25 patients come for follow-up. Daily, one or two patients are brought in an excited condition and, in a week, one patient may be brought tied.

A nominal fee is charged for registration, Rs. 4/- for new cases and Rs. 2/- for old. In the outpatient, notes are maintained on slips of paper. Since the numbers are increasing it would be better to open a file. This will facilitate record keeping. About 15 minutes are spent with a new case and about 5 minutes with a patient for follow-up. Free medication is given for a month. Medication is in adequate supply and newer drugs are also available. Modified ECT's are administered on an outpatient basis when required. Lack of adequate number of clinical psychologists and psychiatric social workers has resulted in almost no psychosocial intervention being provided.

The outpatient service is housed in a separate building newly constructed for this purpose. Although it has a broad verandah and 2 rooms for interviewing, it has not been adequately designed for future expansion. The construction is also of rather poor quality with cracks appearing on the walls.

## **Inpatient service**

The living arrangements in the wards are fairly good. Since the bed occupancy has been brought down, there has been scope for improving the day to day requirements of the patients. The wards are cleaned every day. Adequate cots with bedding and colored linen give the wards a cheerful look. Linen is changed twice a week. Attention to small details, such as providing half-curtains for the windows on the female side, gives many of the wards a cottage-like appearance. Patients are allowed to bathe every day and provided a fresh set of clothes twice a week. Towel and adequate toiletries such as soap and oil are given for each patient. Although wearing of hospital clothing is mandatory, care has been taken not to give it a very monotonous appearance. Wherever possible, instead of the gown for female patients, culturally more appropriate clothing such as salwar kameez and saris have been provided. The male patients are given shirt and pajama.

Since the time of the British, there is a small hair-cutting saloon. Even today, many of the male patients go there for a shave and haircut. Head shaving is done when medically indicated. Anti-lice preparations are used routinely. Mosquitoes are controlled mainly through chemical repellents and spraying of the campus.



The kitchen is housed in a separate building with adequate light and ventilation. Food is hygienically prepared on gas. The dietician or medical officer checks the cooked food. Three meals plus tea amounting to about 2500 calories per day at the cost of Rs. 15/- is provided. The diet is supplemented with seasonal fruits and fruits grown in the compound such as mangoes. There are 2 dining halls for male and female patients. All ambulatory patients are sent to the dining hall for their meals. Tables and benches have been provided and patients are served the food on steel plates. Drinking water facility is available both in the dining halls as well as the wards. The patients enjoy their meal times and are often seen interacting and helping one another. This is another area where efforts have been made to preserve the dignity of the mentally ill person.

Basic laboratory investigations are available for routine blood, urine examination and VDRL. Recording of EEG is done. Patients are managed using mainly pharmacotherapy and ECT's (modified and direct). Single cells are used only when unavoidable.

Psychosocial interventions, behaviour therapy and psychological testing are reported as being provided, but it is not clear as to how these are carried out in the absence of personnel. Recreational facilities are available such as television, games, reading, music and bhajans. Occupational therapy has been restarted with the appointment of a young and dynamic occupational therapist. Vocational sections such as carpentry, tailoring and weaving are present, but not actively utilised. The occupational therapist has involved a few recovered patients in the making of greeting cards, candles, plastic bags and rakhees and these have been appreciated and bought by the public.

There are no open or family wards. Family members are permitted to visit the patient in the ward. The psychiatric nurses utilize these visits to educate the family about the illness and facilitate the return of the patient to the family.

The Medical Superintendent has been constantly trying to improve the image of the hospital and make it more open to the local community. There is good liaison with other voluntary agencies and efforts are on to involve them in a more productive and sustainable manner. Many of the dates marked to commemorate special days such as Mental Health Day, Disability Day etc. are celebrated with cultural and health education activities for the community. Ganesh puja, being the major local festival, is celebrated on a particularly grand scale over a period of 7 to 9 days. Every year the hospital has been amongst the prize winners for the stage decoration. The bhajan group comprised of attenders and patients is also very popular. As a result, large numbers of the local population come to the hospital to enjoy these programs. An innovative programme introduced this year was a mental health exhibition during the same time. Mental health educational material was also printed on



pamphlets (sponsored by a local donor) and distributed along with the 'prasad'. Such activities serve not only to increase the awareness of the public, but also reduces the stigma and isolation of the mentally ill person.

### **Community service**

The hospital is currently running four community-based extension services, three at the taluk level at Sanghameshwar, Devrukh and Lanja and one at the district level in Sawantwadi (Sindhudurga district). Services are also provided to a school for the mentally retarded at Chiplun. These services are being run single-handedly by the MS with the help of a clerk for record keeping and drug distribution. Although fairly arduous and physically taxing, the MS feels that these services have considerably reduced the pressure on the hospital for admission and enabled them to discharge many patients. The follow-up rates at these clinics are also good and the patient and family appreciate the service since it saves them time and money.

Training programmes for medical officers, nurses and multi-purpose workers have been conducted. Orientation to primary school teachers on mental retardation was also conducted.

### **Legal aspects**

The board of visitors has been constituted in compliance with the Mental Health Act, 1987. It has the District Session Judge, the local civil surgeon, Public Works Department etc as members. The board of visitors meets once a month. No public interest litigation has been filed against this hospital. Although the conditions are far better than in most of the other mental hospitals, further improvements can make it an ideal mental health facility. Staff and patients need to be sensitized about the rights of the mentally ill.

### **SUGGESTIONS**

- The MS is a dynamic, young psychiatrist and should be immediately supported with more mental health professionals, especially psychiatrists, clinical psychologists and psychiatric social workers.
- Most of the present wards can be converted to open wards with facility for the relative to stay with the patient.

Toilets and bathing facilities to be improved.

- Special wards and single rooms with attached toilet to be provided on payment basis.
- With adequate staff, emphasis on psychosocial intervention should be increased.



- Occupational therapy to be further strengthened to include more patients and also some ward based activities.
- Day care centre and sheltered workshop can be started with the involvement of local voluntary organizations.

## **Summary and suggestions for the State**

The state of Maharashtra has a total of 5695 beds in the 4 mental hospitals constituting almost one fourth of the total bed strength of mental hospitals in the country. With the exception of Ratnagiri, the number of long stay patients in the other 3 hospitals, indicates that these facilities are perceived as 'dumping grounds' rather than therapeutic centers from which the mentally ill recover and return to their homes.

Mental health services in Maharashtra have received special attention in the last two decades. Dr. S. M. Channabasavanna, Ex- Director and Professor Emeritus in Psychiatry at NIMHANS, Bangalore was an advisor for mental health services to the government of Maharashtra for a period of five years. Several positive changes were initiated during this time. The emphasis was to improve the basic living conditions and to ensure that adequate quantity of food is hygienically prepared. Improvements in infrastructure such as toilets and bathing facilities, lights and fans were made. The cooking arrangements were significantly improved with cooking gas facility and use of stainless steel for cooking and eating purpose and storage of food in closed containers.

A number of staff were deputed for training to NIMHANS, Bangalore. While the psychiatrists underwent a short sensitization program, the nurses came for the diploma course in psychiatric nursing. These staff have been successful in introducing further improvements on their return.

However, despite these changes, conditions continued to be less than adequate. This resulted in a public interest litigation being filed against the Yeravada hospital in Pune. A contempt of court petition was also filed. The court issued a directive to bring about improvements on 64 different counts. The contempt of court order was dismissed in July 1998. However, as a result of this order, further improvements were brought about, not only in the Yeravada hospital, but also in the others. The present report indicates, however, that a lot still remains to be done in order to provide quality care for the mentally ill and preserve their basic right to live a life with dignity.

## **SUGGESTIONS**

- The Mental Health Act 1987 has to be fully complied with. At present, the



Indian Lunacy Act is also being used especially for admissions and discharges.

- The present system of making voluntary admissions as paying cases must be removed. Most of the involuntary admissions through magistrate's order were being done in order to circumvent this. Charges can be fixed on the basis of income and free treatment provided for patients with an income below a certain sum. A social worker can obtain this information at the time of registration or admission. When special wards are introduced, utilization of these services is to be charged irrespective of income.
- A master plan to be drawn up for downsizing the three large facilities at Yeravada, Thane and Nagpur. Additional infrastructure or professional staff for their present size will continue to pose problems. The downsizing will have to be done in a phased manner and will require a series of steps to be taken before this objective can be reached.
- Maharashtra is geographically a large state. Unless psychiatric services are available at the taluk /district level, there will continue to be a pressure on the hospitals. Long stay admissions are necessary only for a small group of patients who are non-responders to treatment or have severe disability. For the majority, long duration of stay in the hospital is not only a burden on the State, but more importantly detrimental to the patient and the family. The reduced contact with the family decreases the emotional bonds within the family structure and the prolonged institutionalization results in loss of functional and social skills of the patient.
- Short stay and open wards, as is the case in general medical hospitals, need to be started immediately so that new admissions are treated adequately and sent home as soon as possible.
- Structured ward based activities, using behavioural techniques, to be introduced to improve daily living skills especially in chronic patients.
- Occupational therapy with an emphasis on pre-vocational and vocational skills, to be started to help individuals develop a work habit, prevent atrophy of existing skills or to learn new skills.
- All the hospitals have enough ground space to have a good day care facility and sheltered workshop. These are to be started with the support and involvement of local voluntary and non-governmental organisations.
- Outpatient services in the existing hospitals to be improved and extension services, as is being done in Ratnagiri, to be started so that readmission rates can be reduced.



- Existing staff to be motivated with in-service training, regular meetings, monetary incentives and participation in workshops and conferences to reduce burnout and increase their productivity.
- New professionally qualified staff to be recruited. However, all such post should be full time, non-practicing posts. At the same time, pay scales have to be revised and upgraded commensurate with qualifications. Better working conditions including; staff quarters, staff room and toilets, changing rooms for nurses and attenders and duty doctors room should be provided. Till such time as these posts are created and filled, part-time posts on contract basis can be considered.
- Intensive care units for medical and psychiatric emergencies, visiting consultants in certain specialties and better laboratory facilities to be introduced.
- All hospitals to develop improved liaison with teaching medical colleges, nursing colleges, as well as schools of social work and departments of psychology in the area. This will be mutually beneficial and optimally utilize the existing human resources.
- The children admitted in the Yeravada hospital must be immediately shifted to a more conducive environment or else a separate facility with specialized inputs made for them. Their current hospitalization amounts to a gross violation of their human rights.



# **CHAPTER-25**

## **MADHYA PRADESH**

### **INTRODUCTION**

Madhya Pradesh is the biggest state in the country. It is centrally located in the country and seven states Andhra Pradesh, Maharashtra, Uttar Pradesh, Orissa, Rajasthan, Gujarat and Bihar surround it. The entire land area of 443, 446 square km. is divided into 45 districts for administrative functioning. Madhya Pradesh has a population of about 66 millions. To serve the mental health needs of the state, there are two mental hospitals, one in Gwalior city and one in Indore. Apart from these two mental hospitals, the state has 6 medical colleges. Each medical college has a unit / department of psychiatry with one lecturer. There are plans to develop these psychiatric units into full-fledged departments of psychiatry and bring them under the administrative control of the Directorate of Medical Education.

There are about fifteen psychiatrists in private practice, but they are concentrated mostly in the urban areas. Madhya Pradesh has two major public sector industries: The Bhilai Steel Plant at Bhilai and the Bharat Heavy Electrical Limited at Bhopal. These industries have fully functioning psychiatric units attached to their general hospitals, which are specially meant for their workers and their families. Qualified psychiatrists manage these units. Besides this there is a private hospital at Indore which has both outpatient and inpatient services. However, the number of trained psychiatrists available for the population of Madhya Pradesh is still inadequate.

### **GWALIOR MANASIKA AROGYASHALA, GWALIOR**

#### **Background**

The hospital was established in the central jail premises in the year 1935, with an accommodation for 30 patients. In the beginning it was only a custodial institution. The OPD services were started in the year 1950 and child guidance clinic was added in the year 1960. After the implementation of the Mental Health Act 1987 and the order of the Supreme Court in response to a public interest litigation, there has been a spurt of activity in improving quality of care. By a gazette notification dated 25/10/94, the institution was declared as an autonomous institution and the name was changed from Mental Hospital, Gwalior to Manasika Arogyashala. For efficient and better management of the hospital a management committee and many sub-committees like finance, accounts, purchase, rehabilitation, construction, and



welfare have been formed. The hospital has received a special grant from the Government of India and additional funds from the Government of Madhya Pradesh.

## **Infrastructure**

Most of the old buildings have been renovated. New family ward, open ward and dining hall have been constructed and are ready for occupation. There are 3 male and 3 female closed wards. The office, outpatient services, ECT facilities, drug counter and rehabilitation facility are located in one block. All the buildings are being renovated with a new look. The kitchen, water facility, electricity have to be improved. The drainage system, which is of open type, needs immediate attention.

The hospital has a bed strength of 212, of which 157 are for male and 55 for female patients. There are 60 chronic patients out of which 23 male and 37 female patients live in separate wards.

## **Staff pattern**

There are 6 posts of psychiatrists, however, currently there is only one qualified psychiatrist. Though there are sanctioned posts for 3 clinical psychologists and 7 assistant clinical psychologists all the posts remain vacant. There is only one medical social worker working and 8 posts are vacant. There are 16 medical officers, several of them having post graduate qualification in other specialties. These include an anesthetist who looks after the modified ECT program, a pathologist to look after the laboratory and a radiologist who is in charge of the radiology department. The post of occupational therapist is vacant. Out of the 59 posts for nurses, 26 are vacant and currently 33 are working. There is no post of trained psychiatric nurse.

There is an urgent need to take up steps to train all the categories of staff. Currently, four medical officers are undergoing training in psychiatry at NIMHANS. All the vacant posts should be filled up. As a matter of fact, even the post of the Director is currently vacant.

## **Admission and discharge**

Two thirds of the admissions are voluntary admissions and one third by order of the court. About 30 patients, 14 male and 16 female are staying in the hospital for more than 5 years. There has been a continuous decline in the number of deaths per year. The current occupancy is about 90%.

## **Finance**

Following the intervention of the Supreme Court, there has been a considerable increase in the funds from Rs. 66.75 lakhs in 1995 to Rs. 387.45 lakhs in 1996. The



salaries take away 76% of the budget, 11% is spent on food and another 10 to 11 % on drugs. Most of the additional budget has been utilized for development activities like building a new X-ray block, modified ECT block, open wards, family wards, new dining hall, and renovation of the old buildings. The additional budget provision should continue for some more time so that all the facilities can be upgraded to make this institution a modern one.

## **SERVICES**

### **Casualty and emergency service**

Casualty and emergency service is available, with a roadworthy ambulance in the hospital.

### **Outpatient service**

Regular outpatient service is available daily from 8.30 am to 2pm. On an average, 20 to 35 new patients visit the outpatient. A nominal charge of Rs. 5/- is made for registration. Poor patients are given free drugs for a period of one month to 3 months. Modified ECT is administered for both inpatients and outpatients, and on an average 25 to 30 patients receive ECT. Waiting room facilities are inadequate. Toilet facilities are very poor. There is no telephone or canteen facility and patients who are on outpatient treatment use an open space in front of the administrative block for their stay.

### **Inpatient service**

The buildings are getting renovated and a new open ward and family ward have been constructed. It is interesting to note that the hospital authorities are planning to hand over the open ward to an NGO for management. This would be a novel experiment. The number of bathrooms and toilets in the wards are not adequate. In one of the female chronic wards there are no toilets and a small drain running along the wall inside the ward is used as a toilet. In the chronic female ward, fecal matter was found smeared on the walls.

In some wards, cement blocks are used as beds for patients to sleep. More than half the patients have no cots to sleep on or mattress, pillows, sheet or blankets. There is no laundry service to wash the linen of the hospital. There is no proper washing facility and the drainage system is inadequate. It is recommended that a mechanized laundry be installed to wash all the hospital linen so that linen and clothing can be replaced frequently.

The food is cooked on gas stoves and the patients are involved in cooking and food preparation. Food is prepared in hygienic conditions. Hot water is available



round the clock to the kitchen through a solar water heater. Food is stored and carried in closed containers for distribution in the wards. All the male patients are lined up in the new dining hall and food is served with dignity. For the female patients they are lined up in the veranda outside their wards and food is served to them. Both quality and quantity of food is satisfactory. Rs. 15/- is spent per patient per day for regular diet and Rs. 25/- for special diet.

Treatment is mainly medical including drugs and modified ECT. There is hardly any psychosocial input or use of behavioral techniques. There is no structured daily activity for patients. There is very minimal recreational activity. Occupational therapy facilities and rehabilitation services are yet to pick up. A new building has been constructed for housing rehabilitation activities for the patients. Currently handlooms have been installed to make dhurries (cotton carpets) and a few patients are involved in this activity.

Basic laboratory investigations are available including routine blood and urine examination and serum lithium estimation. ECG and x-ray facilities are available. Since there is no clinical psychologist psychological testing is not carried out.

There is no medical record section and the hospital is planning to computerize the system of record keeping. There is a need for qualified staff in this section.

### **Community service**

Under the National Mental Health Program, the district of Shivpuri is likely to be taken up by the hospital. Currently, psychiatric services are provided to the central jail.

### **Teaching activities**

Gajra Raja Medical College, Gwalior and Jiwaji University have declared the institution as a teaching institution. The hospital authorities are actively involved in getting MCI clearance.

### **Legal aspects**

Board of Management has been appointed with the Directors of NIMHANS, Bangalore, CIP, Ranchi, IHBAS, New Delhi and Professor of psychiatry at AIIMS, New Delhi as permanent members. This board is supposed to meet every three months or more frequently if needed. There is no board of visitors. As mentioned in the introduction, a public interest litigation was filed against this hospital and was known as the Mrs. Sheila Barse Vs the State of Madhya Pradesh case. Many of the improvements have been as a result of this case. However, there is still a lot of scope for improvement and the funds allocated should be used judiciously so as to improve the quality of care for the patients.



## **SUGGESTIONS**

- To improve the basic amenities in the wards. Toilet facility should be available in all wards and in the outpatient.
- The drainage system needs to be improved. Proper washing facilities to be provided by starting a modern laundry unit.
- A well-furnished saloon has to be provided for the barber.
- Proper medical record section with qualified staff.
- Filling up of all the vacant posts, especially of mental health professionals. Post of psychiatric nurses to be created.
- Involvement of the NGOs and voluntary bodies in rehabilitation and placement..
- All the members of the staff to be educated regarding the rights of the mentally ill.

## **MENTAL HOSPITAL, INDORE**

### **Background**

The hospital was started in the year 1930 as a mental asylum. Later, in 1950 the name was changed to mental hospital. Before 1947, Indore was in Holkar State and after independence it became a part of Madhya Pradesh. It is 12 km from the city centre. It is spread over an area 8 acres. The hospital building is very much dilapidated. The hospital is located in the main road but there is no outer gate. The front land has been encroached by small shops and hence it is difficult to identify the entrance.

### **Infrastructure**

The hospital has a bed strength of 155, with 110 beds for males and 45 for females. The main (old hospital building) has a tiled roof and is in a dilapidated state. Except the female ward, which has a RCC roof, all the other buildings are with tiled roof and badly maintained. All the wards are closed wards. There is no separate facility for patients with criminal records. There is no special or paying wards. The open space in the campus is all dirty and pigs and dogs are found in plenty. The electricity and water supply are inadequate. The wards have toilets, but the number is most inadequate. Most of the toilets in the female ward have no doors and hence there is no privacy. The male wards have no toilets. There is an open drain running all around the building in front of the cells that are used as toilets by



the male patients. All the patients are provided metal cot without mattress, pillow, and sheets. The female ward, though built recently, needs renovation. In the wards the lighting and ventilation is not sufficient. The fans in the female ward are inadequate. There is no privacy for the female patients and the public can peep through the windows.

## **Staff**

There are only two qualified psychiatrists. One of them is the medical superintendent and is also attached to the medical college. There are 7 posts of medical officers, out of which one is a psychiatrist. There are no posts of clinical psychologists and there is only one social worker functioning. There are 18 nurses and none of them have been trained in psychiatric nursing. There are 67 ward attenders and no posts are vacant. There are other posts like those of an electrician, barber, mechanic etc. totaling 16. There are 10 administrative staff. The RMO, 1 nurse, 2 ward attenders, 2 sweepers and a cook stay in the campus.

## **Admissions and discharge**

Admissions are made through court orders only and till date no voluntary patients have been admitted. All the admissions and discharges are governed by Mental Health Act 1987. Discharge problems are mainly due to false address given by the relatives, change of address and patients with unknown address. There are 40 men and 55 women staying in the hospital for more than 5 years.

## **Finance**

The hospital has a budget of Rs. 65.5 lakhs, which is inadequate. Major part of the budget (80%) is spent on salaries, and the rest on drugs (9%), food (10%) and linen (1%). There is no budget allocation for furniture and maintenance.

## **SERVICES**

### **Casualty and emergency service**

The duty doctor provides casualty and emergency services. There is no ambulance in the hospital to provide emergency transportation.

### **Outpatient service**

There is regular outpatient service everyday between 8 am to 2 PM., and, on an average, 50 patients avail of this service. Poor patients are given free drugs for a period of 2 weeks. There is no drinking water facility, no telephone and no toilets in the outpatient.



## **Inpatient service**

Most of the male patients are in cells and many of them are chained. There is no toilet facility. The main door is always kept closed and this makes the patient inaccessible. No mattress, no pillow, no blankets are provided to the patients. Water, electricity, fan are grossly inadequate. In the female wards, again there is poor toilet facility and inadequate number of fans and lights. More than 50% of the patients sleep on the floor. The patients are given hospital uniform; green shirt and khaki half pant for men and green gown for women. Quality of linen is very dirty and not washed regularly. Adequate quantity of linen for each patient and frequent change is essential. There is no proper laundry service and a mechanized laundry is highly recommended. Head shaving is done regularly for both men and women.

Food is prepared in a small, dirty and dilapidated room. With the result there is no proper cooking of food and no food hygiene followed. The quality of the food is very poor. Currently they are spending RS.14/- per day per patient for food. The budget for the food has to be improved. Water supply facilities in the kitchen are inadequate. There are no proper plates and mugs for the patient. There has to be a drastic improvement in the quality and quantity of food and at least 2,500 calories should be given for each patient. Several voluntary agencies come forward to provide food on festival days and all the patients enjoy that food.

There is a small, basic laboratory in the outpatient where only routine blood and urine examination is done. There is no x-ray facility. There is no facility for psychological testing. Treatment is mainly medical with drugs and direct ECT being administered. The hospital has very poor recreational activities for the patients. There are no rehabilitation activities at all. Except lunch, dinner and medicines given to patients at specified times, the patients spend their time sleeping or sitting idle or sometimes fighting with other patients. The patients are made to sit out in the open air only for 2 to 3 hours in a day.

Medical record section is poorly maintained, needs trained manpower and space to store the records.

## **SUGGESTIONS**

- The main building, which currently houses the male patients, should be demolished and a new building with open and family wards should be built. There should be a separate ward for patients with a criminal record. The female ward has to be renovated. The water supply, electricity, toilet, and other basic facilities have to be improved. A compound wall with a gate has to be built.
- Majority of the admissions should be made voluntary.



- All vacant post should be filled up. Posts of clinical psychologists and psychiatric social workers and psychiatric nurses need to be created.
- The number of post of nurses should be increased and some of the motivated and committed ones should be identified and deputed for inservice training in psychiatric nursing.
- The number of staff quarters to be increased.
- A separate kitchen with gas facility to be constructed. Food should be prepared hygienically under the guidance of a dietician.
- Ambulance facilities to be provided.
- Laboratory facilities to be upgraded to provide at least serum lithium and other investigations routinely required.
- Medical record section to be improved.
- Psychosocial intervention has to be provided as routine care and rehabilitation work taken up seriously.

## SUMMARY

Madhya Pradesh is the largest state in the country with 45 districts. Mental health facilities are available in the 6 state medical colleges at Raipur, Indore, Bhopal, Gwalior, Jabalpur, and Rewa and in the two mental hospitals at Gwalior and Indore. Mental health facilities in other cities, district hospitals and rural areas is totally lacking. Postgraduate training programs in psychiatry, clinical psychology, psychiatric social work and psychiatric nursing are yet to be started. The state mental health authority needs to be strengthened and given more powers.

The two mental hospitals at Gwalior and Indore have received a lot of negative media attention. Although, the public interest litigation and ensuing court order have brought about some changes, especially in Gwalior, the conditions in these 2 settings are far from desirable. The human rights of the mentally ill continued to be violated in Gwalior and have been totally ignored in Indore. This reflects a lack of sensitivity on the part of the health administration.

With the help of an expert committee, the state government has prepared a document for improving mental health care. The recommendations made by this committee have to be taken seriously and implemented at the earliest. Care should be taken that money is spent on improving the basic living conditions and providing appropriate treatment for the patients. Greater transparency in the functioning of these institutions is needed and an external committee should do the monitoring.

The nature of care has to change from custodial to therapeutic. In addition to



biological methods of treatment it is imperative that an equal emphasis be placed on psychological and social therapies. Only when the bio-psychosocial model of care is implemented, will treatment for the mentally ill person be complete.

Psychosocial rehabilitation is a much-neglected area. Patients can be discharged from the hospital and reintegrated in the community only when specialized inputs in rehabilitation are provided. The success of rehabilitation programs also depends on the professionals optimally utilizing the resources of the community. The doors of the hospitals must be opened to allow for greater participation by non-governmental and voluntary organizations.



# **CHAPTER-26**

## **PUNJAB**

### **INTRODUCTION**

The state has 14 districts with a population of 200 million. The main source of income is from agriculture. 70% of people are engaged in agriculture, which is the highest rate in India. There are four medical colleges situated at Amritsar, Ludhiana, Patiala and Faridkot. The health infrastructure is reportedly good. There is only one mental hospital at Amritsar, which caters to the needs of neighboring states of Haryana and Himachal Pradesh. These states have no mental hospitals. There are departments of psychiatry in medical colleges at Abohar, Bathinda, Hoshiarpur, Jalandhar, Kapurthala, and Moga.

### **DR. VIDYASAGAR GOVERNMENT MENTAL HOSPITAL, AMRITSAR**

#### **Background**

Dr. Vidyasagar Government Mental Hospital, Amritsar was established immediately after partition in 1950, when all the Hindu and Sikh inmates of Lahore Mental Hospital were shifted to Ranchi Asylum and later shifted to Amritsar Mental Hospital. This hospital with an area of twenty six acres, was established on the outskirts. Initially the bed strength was 50. This hospital had its golden period during the time of Dr. Vidyasagar who had laid strong foundations for this hospital in terms of infrastructure and manpower. This is a Centre where the families' involvement in the care of mentally ill was started for the first time. It has housed patients from Pakistan and undivided Punjab (now Punjab, Haryana, Himachal Pradesh, and Chandigarh). It is located a short distance away from the city center. Many patients are living here for more than 4 decades. It has a bed strength of 850.

#### **Infrastructure and staffing**

The buildings are owned and maintained by the Government of Punjab. They are in a poor state and require urgent attention with regard to maintenance. The Medical Superintendent is a non-psychiatrist. There are 4 qualified psychiatrists, 1 clinical psychologist, 2 psychiatric nurses, 15 general nurses and 60 ward attenders. There are no psychiatric social workers or occupational therapists. The working hours are eight hours per day. The staff members are poorly trained and amotivated.



## **Finance**

Ninety percent of the budget is spent on salary. At present the hospital has run into huge debts to contractors whose payments are delayed for years. Occasional donations in cash and kind are taken by the hospital. The immediate needs of the hospital are most often met with public donations. Budgetary allocation is highly inadequate.

## **Admission and discharge**

At present, almost all admissions are involuntary. 2 wards are used to admit acute cases on voluntary basis. Here family members are allowed to stay with their patients.

## **SERVICES**

### **Casualty and emergency service**

General emergencies are reasonably well managed. Ambulance services are available. However, laboratory facilities are inadequate.

### **Outpatient service**

There is a new outpatient block with adequate facilities. The outpatient is run on a daily basis with an average attendance of 50 to 70 patients. Free drugs are given. Doctors work for 3 hours by rotation. No specialized investigations are done. Waiting time for the patients is 15-20 minutes. Approximately 50% of the patients are provided free drugs. Records are poorly maintained. Even though patients are charged Rs. 5\/- for registration, case records are maintained poorly. There are no staff in the records facility and the treating team finds it difficult to trace old records. Very rudimentary facilities are available for all investigations. Psychological tests are carried out with the services of one clinical psychologist. No emergency investigations are done.

### **Inpatient facility**

Two wards are used to admit acute cases. Family members are allowed to stay with the patients. The wards where criminal patients are kept are over crowded and lack basic facilities. There are no cots, mattresses or adequate toilet facilities. Patients defecate in the open space. They bathe in the open. All the other wards are in enclosures with high walls and gates and are locked all the time. Visitors are not allowed to enter these wards. Poor hygienic conditions like inadequate water, lighting and overall uncleanness are the order of the day. The wards housing old patients, mentally retarded and epileptics are in the worst condition. They have to be demolished immediately.



Linen, uniforms are inadequate, and dirty. Many patients who have recovered or with few residual symptoms, who need not stay in the hospital, are there for many years. Poorly involved family members, administrative hurdles, inactive police, judiciary, and NGOs are all contributing to this. It is in the midst of bad publicity as there were a few scandals like a woman patient becoming pregnant and delivering a child in the hospital. The hospital staff attacked the medical superintendent on one occasion. Recreational facilities are restricted to a few television sets.

Dietary services are very inadequate. Rs. 8/- is spent for food per patient per day. The quantity and quality are awfully inadequate. Firewood is used for cooking. Patients work in the kitchen. Food is served in the corridors.

### **Rehabilitation service**

The rehabilitation services are inadequate with no involvement of NGOs and other volunteers. There is no placement of patients for any job situations outside.

### **Community services**

There is no community service or any other staff training programme.

### **Rights and legal issues**

Patients are allowed to write letters to their relatives. Staff members are not aware of the rights of the mentally ill. Board of Visitors are present in this hospital and they meet once in 3 months and Board of Visitors are practically ineffective. There is one public interest litigation which is pending in the High Court.

### **Summary and suggestions for the State**

This is an old mental asylum set up and needs immediate attention and improvement. Many patients, who were sent through reception order and improved, continue to stay for several years without any efforts at rehabilitation or discharge.

This hospital requires immediate structural changes. Food quality and quantity requires urgent attention. Safety of female patients is a great cause for concern. Legal problems in sending them back without going through the Court is a major hurdle in discharging the improved patients. More psychosocial interventions need to be developed to overcome this problem. Judiciary needs to be sensitized regarding this issue. Patients from neighboring states are dumped in far away Amritsar Mental Hospital. These states should generate their own resources to provide adequate care for the mentally ill.



# CHAPTER-27

## RAJASTHAN

### INTRODUCTION

The State of Rajasthan is the 2<sup>nd</sup> biggest State in the country with an area of 3,42,239 of kms. It is situated in the north-west of India bordering Pakistan on one side and Haryana, Punjab, Uttar Pradesh, Madhya Pradesh and Gujarat on other sides. The population of the state is about 44 million and it is estimated that by the end of the century, it will increase to 56 millions. The density of population is 149 per sq. km. The state consists of 32 districts, with the state capital at Jaipur.

### Background

The history of modern psychiatric facilities in Rajasthan is not very old and goes back to the fifties in the post independence years. Prior to that, the mental patients were put in two primitive mental hospitals or lunatic asylums situated at Chandpole Gate, Jaipur (1912) and in a princely building 8 kms. away from the sun city of Jodhpur (1940). These two mental asylums were inadequately equipped, had minimum staff and poor living conditions.

The first modern mental hospital, the present facility at Janta Colony was established at Jaipur in the year 1952. The psychiatric patients were transferred from the custodial home at Chandpole Gate to this new building. Dr. T.N. Bhargava, a non-psychiatrist was the first superintendent of the new hospital. The hospital was renamed as "Psychiatric Centre" in the year 1972. Dr. Shiv Gautam, is the present superintendent.

In 1952 the centre had a bed strength of 180. At present the hospital has a total bed strength of 312 which includes 20 in the emergency ward and 12 in the deaddiction ward. Since 1979, the psychiatric centre was recognised as a post graduate training centre of SMS Medical College. Every year 3 students are selected for the MD in psychiatry course. The centre has been recognized as one of the 5 regional centres for the implementation of the National Mental Health Programme and is actively involved in the implementation of the District Mental Health Programme.

The catchment area of the hospital is the whole of Rajasthan and adjacent states of Uttar Pradesh, Madhya Pradesh, Haryana, Punjab and Delhi. The admission facilities in the centre are free to every person irrespective of the state and free medication is provided.



## **Infrastructure**

The hospital has a general hospital type of architecture. It has four closed ward, one open ward, and four pavilions for chronic patients two each for males and females. The hospital does not have a separate outpatient building, family wards, ward for children and adolescents, criminal ward or rehabilitation centre. There is no modern laundry and modern kitchen. Very few quarters have been provided for the staff.

## **Staff pattern**

The Medical Superintendent is a Psychiatrist. He is assisted by a Deputy Medical Superintendent. There are six civil assistant surgeons out of whom three are qualified psychiatrists. There is only one clinical psychologist and one psychiatric social worker. Most of the vacancies has been filled up. Faculty of the SMS Medical College to which the hospital is attached also participate both in the outpatient and inpatient. However, there is a shortage of qualified mental health professionals like psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses. None of the medical staff stay in the campus. Only the duty doctor is available after the working hours i.e. 8 a.m. to 2 p.m. Nurses and attenders have to work on shift basis.

## **Admission and discharge**

The admission procedure is only by the Mental Health Act, 1987. Majority of the admissions are voluntary, a small percentage (4 percent) being through court orders. Escapes form about 10% of the admissions. It is heartening to note that there has been no suicide in the hospital in the last 5 years and death rate in the hospital has come down. There are 74 people who are staying in the hospital for more than one year out which 30 male and 44 are female patients. The hospital administration has taken up this issue seriously and adopted various methods to send patients home. The average duration of stay in hospital is about 20 to 25 days. The involuntary admissions are screened by the board of visitors and patients are sent home either with relatives or with hospital escort. An NGO named Medicare Relief Society of the Hospital helps in the discharge.

## **Finance**

There is no plan budget provided for the developmental activities. The hospital has received one time additional grants for the development of community mental health care. There is a need to improve the finances of the institution and additional finance are required for developing infrastructure. Hospital has received donations in kind.



## **SERVICES**

### **Casualty and emergency service**

There is facility for casualty and emergency services. About 70 to 80 people per week are utilizing this facility. Out of them 20 to 40% get admitted. There is a facility for short stay ward. Ambulance is available, but there is only one driver.

### **Outpatient service**

There is facility for daily outpatient service between 8pm. to 2 pm. More than 100 patients avail of the services each day. Psychiatrists, general duty medical officers and clinical psychologists run the service. There is no separate outpatient block. Free drugs are provided for a period of 2 weeks and in the outpatient direct ECTs are administered. The record system needs to be improved and run by staff trained in handling of medical records. There is no canteen facility in the outpatient. Telephone facility is not adequate.

### **Inpatient service**

Acute wards are reasonably maintained. Chronic wards for male and female patients are over crowded and in need of immediate attention. The patients are provided with a steel cot, mattress and a white sheet. Pillows are not provided to all the patients. A few patients sleep on the floor because of inadequate number of beds. There is no separate laundry. The washing is entrusted to a contractor.

Toilet facilities are not very clean and maintenance is very poor. Amenities such as mug and buckets in the toilet and bathrooms are not provided. The supply of water is not adequate. There is a need for more fans in the wards. The service of only one barber is available and the hospital needs at least 3 barbers. There is a need for a separate hairdressing room with facilities like chair, table, mirror, etc., for men and women separately.

Routine investigations including lithium estimation is available. Psychosocial investigatory facilities are also available. Facilities for special investigations like computerised EEG are not available. All investigations are free of charge for poor patient. Only direct ECTs are given. There is no facility for modified ECT. Medical records are poorly maintained. One nurse and a ward boy manage the records section. There is a need for trained manpower and infrastructure.

Food is prepared in an old building without adequate ventilation. Gas cooking facility is present. There is no post of dietician. The patients are involved in food preparations. Patients are provided with 250 ml of milk at 8 a.m, lunch at 12 noon, at 4.30 to 5 seasonal fruit and 250 ml of milk and at 6.30 p.m. to 7.30 p.m. dinner is served.



There is no dining hall for serving food to the patients. All the patients are lined up in the verandah and food is served in steel plates, katori and steel tumbler. The lunch and dinner consists of roti, dhal, curry and rice. The quantity is served according to the individual requirements. Special diets are provided on Diwali and other national holidays

There are no rehabilitation services and this need to be started soon.

### **Community service**

The hospital is actively engaged in community based activities. Under the NMHP programme, it runs a mental health clinic at a Primary health care (PHC) centre. Deaddiction camps are frequently organised. A school mental health programme is also being carried out. The hospital is in need of a vehicle and driver for continuing the community services.

### **Legal issues**

There is Board of Visitors. Mental Health Act, 1987 has been fully complied. There are no public interest litigations.

### **SUMMARY AND SUGGESTIONS**

The state of Rajasthan has one mental hospital in Jaipur with 318 beds. The other mental asylum in Jodhpur has become a part of the medical college in Jodhpur. It has about 85 beds at present. In addition, there are 30 beds each in Udaipur and Ajmer again as part of general hospital psychiatric units attached to medical colleges. In addition, there are post of psychiatrists in 10 hospitals at the district level with about 10 beds each. In all, therefore, about 557 psychiatric beds are available. Approximately, 20 to 25 psychiatrists are in private practice. Despite all this, psychiatric services are available in just 17 of the 32 districts of Rajasthan. This indicates that much more remains to be done in order to make quality psychiatric services available close to the consumer, that is, the patient and family.

- The lack of professional staff is a major handicap. Although training of psychiatrists has started there are no centres to train other members of a multidisciplinary team such as clinical psychologists, psychiatric social workers and psychiatric nurses. It would be prudent to start such training centres which would cater to the needs of the state and region. The suggestions are outlined below:
- Since the outpatient services have been steadily increasing there is a need to have a separate building. This facility should have adequate staff especially in terms of mental health professionals. It should also be built on modern lines with a waiting hall with adequate seating, interview rooms



that provide privacy, rooms to carry out psychological testing and intervention etc. It should be well lit and ventilated with toilets, drinking water, telephone and canteen facilities.

- Basic infrastructure in the wards need to be improved. There should be better toilets in adequate number. Hot water facility to be provided in winter. Improved mode of communication between the wards such as telephone and intercom. Phone facility that can be utilised by patients and relatives. Kitchen of the hospital needs to be upgraded. A modern system of laundry so as to provide clean linen.
- Separate facilities to cater to the needs of children and adolescents.
- Criminal patients must be kept in a separate unit.
- Family wards to be started with specialised inputs for working with families.
- Record section needs to be better equipped with trained personnel .
- Laboratory investigations in the hospital need to be upgraded. An autoclave machine for central sterilising.
- A separate clinical psychology unit with adequate professional staff and testing and other equipment to carry out psychological testing and psychosocial and behavioural methods of treatment.
- Departmental library of the hospital needs to be upgraded with more periodicals and journals and computer facility to be provided.
- A separate rehabilitation unit with new building, staff and equipment should be provided.



# **CHAPTER-28**

## **TAMIL NADU**

### **INTRODUCTION**

Tamil Nadu is situated on the south eastern side of the Indian peninsula. It is the eleventh largest state in India and occupies 4 % of the country's total area. It has an ancient history going back some 6000 years and represents the nucleus of Dravidian culture in India. The state has an area of 130,058 sq km. Chennai (earlier Madras) is the capital city. It has a population of 55,638,318. Literacy rate is 63.7%. Per capita income is Rs 4428. The state is divided into 25 districts. Tamil Nadu currently has only one mental health institute, the Institute of Mental Health, located in the State capital, Chennai.

### **INSTITUTE OF MENTAL HEALTH, KILPAUK, CHENNAI.**

#### **Background**

The institute has its origins in a private run psychiatric establishment in 1793/1794, by surgeon V. Connolly. Connolly sold the asylum at 'nearly three times the building's estimated value. In 1815 the Government of Madras objected to the repeated transfer of the asylum's lease. The principle of selling not merely the building, but the charge of patients contained in it, to any individual, however qualified, was thought utterly objectionable and could not be sanctioned by Government (according to the Madras Military Dispatch 1823). Thus surgeon Dalton, then in-charge of the Madras asylum continued to administer it until his retirement when he handed over medical charge of the institution to a surgeon subsequently appointed by the Government, on recommendation of the Medical Board.

The Government Mental Hospital, which was later rechristened as the Institute of Mental Health is one of the oldest buildings in the city, situated in a lot of greenery in the city of Chennai. The area of the hospital is 63 acres. There is a high wall of 12 feet. The hospital is situated 5 kms from the city centre. It is 5 kms away from the Central Prison. The hospital provides services for the entire state of Tamil Nadu, Pondichery and adjoining states.

#### **Hospital infrastructure**

The sanctioned bed strength is 1800. At the time of evaluation there were 1678 patients (1119 male, 514 female, 42 criminal and 3 children). The institute is administered by a Director. There are 'enclosures' located within high compound walls



where most patients are housed. Mentally retarded patients are kept in a separate "enclosure" as are criminal patients. 3 wards are designated as paying wards, one as an isolation ward. There is a separate alcohol and drug de-addiction ward, built in 1991.

After 5pm all patients are locked within the 'barracks'. There are 16 single cells, some of which are in disuse; some of which are being repaired.

The ambience and functioning are reminiscent of a jail. "Warders" do rounds every half hour. Patients are made to line up for handover.

Most of the buildings are colonial in origin and around 200 years old. The building maintenance is under the Public Works Department of the State Government. The state of the buildings is reflected in the abstract of urgent special repair works submitted by the PWD (1998-99). Of the 50 repairs works budgeted at Rs.1.16 crores; 34 works related to leaking and damaged roofs 24 to toilet, drainage and water supply and 12 to repairing damages in the ward.

### **Staffing pattern**

Staff strength is 796, including specialist staff like psychologists and psychiatric social workers. "Overseers" (ward attendants) are under the charge of the "Head overseer". There are separate posts of occupational therapists and recreation therapists. There are posts of Butler, Weighman, Engine Driver, Water woman continuing with the same designations.

### **Admission and discharge**

Decertification continues to be done by the Board of Visitors as well as by hospital authorities. Difficulties in discharges occur despite social workers' attempts at writing letters / home visits. Attendants sometimes accompany the patients. Faulty addresses often pose difficulties in discharge.

### **Finance**

The fund allocation under non-plan budget has been static at Rs. 8 crores between 1992 and 1996. During 1996, Rs. 4 lakhs was received as hospital maintenance fund. Last year Rs. 60 lakhs was sanctioned towards improvement of infrastructure. On an average, the budgetary distribution is as follows : 35% on salaries, 10% on diet, 1.25% on drugs. Only Rs. 6000/- is sanctioned annually towards maintenance! Current cost per bed per day has been worked out at Rs. 93.22.

The hospital has received donations in kind, especially recreational items such as TVs for the wards.



The financial allocation is inadequate. Mental health is regarded as low priority and receives a very small share of funding compared to other medical services.

## **SERVICES**

### **Casualty and emergency services**

These are present and accessible. However, there is no regular provision to admit emergency cases after 5 pm. There is a short stay ward where patients are admitted with a family member. But this is underutilized. More than two thirds of patients are directly admitted from the emergency. Ambulance services are provided. These are used for referrals to other hospitals.

Basic laboratory, X-ray, EEG facilities are available in casualty. Casualty staff are present around the clock. Referrals for CT scan are sent to the general hospital.

Specialists visiting the hospital include an ophthalmologist and tuberculosis specialist. A move to have other visiting specialists is underway.

### **Outpatient service**

There are daily out-patient services between 8 am to 2 pm. About 400 cases are seen in follow-up and 20 new cases are registered daily. After workup by social worker (welfare officer) cases are evaluated by the psychiatrist. Medical officers are posted to the out-patient follow-up by rotation. Adequate time is allotted to each patient. Waiting space is provided. Adequate privacy is not provided for initial interventions with patients. Free drugs are provided in the out—patients fortnightly or monthly.

Special clinics are run for children, elderly, epilepsy, neurotic disorders and alcohol and drug abuse. Prescriptions are provided in the local language.

### **Inpatient service**

Most of the enclosures resemble a typical jail. There is only 1 toilet for 40-50 patients. Baths are completely open. Although cots are provided for in most wards, there are only 300 mattresses (bed strength 1800). Although 3 sets of linen are provided for each patient, most patients appear to have no linen. There are no fans in the wards. In the single cells the patients sleep next to the toilet. There is no running water available here.

Uniform (green or blue trousers and jackets) is mandatory and 3 sets are provided. Head shaving is often done. There is a barber to attend to face shaving and haircutting. Anti lice measures are adopted quarterly.



Some recreation facilities are provided in the wards.

Female enclosures are slightly better off. They are cleaner and less over crowded. Better quality of care is provided by female warders. Linen appears adequate in this section. One ward has been reconstructed with a private donation. Some of the women attend rehabilitation. Many of the chronic women patients appeared satisfied with the facilities provided.

### **Dietary and pantry**

Food is prepared under the supervision of a dietitian. Diet for different categories is as follows : A class diet Rs. 14/-, B Class : Rs. 7.50 and general Rs. 5/-. Attempts are made to give as wholesome and balanced a diet as is possible given the budgetary constraints. Breakfast is served at 7 am, lunch at 11.30 am and dinner at 4 pm. Patients thus have nothing to eat between 4 pm until the next morning.

Cooking is done using gas, and food transpiration is hygienic.

### **Investigation and treatment facilities**

Routine blood investigation, X-ray, EEG are available in both out-patient and in-patient. Screening for HIV and Hepatitis is available. Psychological testing is also carried out. Direct ECTs were being administered until recently. In the wake of litigation related to ECT, ECT use has declined to a minimum in the institute, and modified ECTs are given.

All the latest drugs used in pharmacotherapy are readily available.

### **Medical records**

The biggest asset here is excellent archival material dating back to the last century. Case files are available from as early as the 1930's. Individual case records are maintained and easily retrieved for follow-up. There is no medical records officer and the statistician is presently looking after the MRD, along with recovered patients. The records need to be computerized and if possible microfilmed for documentation.

### **Rights of Patients**

Patients are encouraged to take part in recreational activities. Social workers write letters to family members on behalf of patients. There is very little private space for visiting family members. There are indeed few visitors each day. The staff (especially the 'overseers') appear to be totally lacking in awareness about basic rights and violations with respect to the mentally ill.



## **Service and facilities**

Electricity and water supply is adequate. However, the lighting within the campus, especially between wards, and the overgrowth in the poorly maintained campus makes it difficult for the staff to move from ward to ward, especially at night. Incidents of assault, intoxicated behaviour by attendants is not uncommon.

Telephone, library and canteen facilities are adequate.

## **Board of Management**

Board of visitors is still operational and meets monthly.

## **Rehabilitation services**

Ward based occupational therapy is carried out by social workers. A separate occupational therapy unit is functioning since 1972, and provides services for about 150 patients. Sections include book binding, tailoring, carpentry, painting, welding and quilt making, industrial therapy section, and the bakery. Incentives are provided to patients working in the bakery. About 100 patients are paid incentive of Rs. 15 each per month. Two to three NGOs are involved with rehabilitation activities.

There is no facility for long-term stay of the chronically ill, who do not require to be in a psychiatric institution.

## **Community services**

Psychiatric clinics are conducted at Poonamalle Health Centre and Melpakkam (Beggar's home). The implementation of the District Mental Health Programme is underway at Trichy. 20-25 psychiatrists are available at the district level. Extension services are also provided to a half way home for mentally ill women.

## **Training**

While the psychiatrists are continuously exposed to research and training, there is little training for the other mental health professionals. There are few psychiatric nurses. There is no sensitization for the ward attendants. There are no inservice training programmes. Lack of promotional avenues and workload are cited as common reasons for staff amotivation.

## **Summary**

The Institute of Mental Health, Chennai, still continues to be a prototype mental hospital. Despite the presence of highly skilled and competent psychiatric staff, and the free use of the most recently introduced psychotropic medications, basic living conditions of patients remains much the same.



## Suggestions

- Infrastructural change - rather than waste so much money on repairs, many of the out dated buildings need to be demolished. New wards in keeping with a modern facility need to be built.
- Walls to be lowered. Prison like gate to enclosures must be removed.
- Although the institute's name has been changed, and words like asylum are not used, terms such as enclosures and overseers reflect the enmeshment of the institute in the last century. It is important to be freed of such shackles of custodial care.
- The attendants need to be trained, sensitised, and brought under
- nursing administration to ensure better monitoring, less evaluation of patient rights.
- Living conditions, toilets, privacy, linen, personnel appearance need to be paid immediate attention.
- The overcrowding within wards submerges any possible attempts at improving quality of life of patients. This has to be addressed by a) decentralizing psychiatric facilities within the state into smaller units. b) rehabilitating many of the mentally ill presently in hospital who do not need institutional care.
- Cells must be abolished.
- More open wards, with admission along with family, needs to be encouraged. Families need to be educated about mental illnesses and their treatment.
- Awareness / education can be provided at the OPD level.
- Greater privacy during OPD evaluation by social worker.
- Inservice training for mental health professionals.
- Deputation of more nurses for psychiatric nursing training.
- Dietary provision to be increased
- Improvement of campus facilities, lighting, maintenance.
- More doctors to be available after 2 pm.
- Emergency services to be extended for 24 hours.
- Rehabilitation facilities to be utilized by more patients.
- Multi-disciplinary team approach and regular administrative meetings may



help in smoothening out staff functioning and other issues.

- More liaison with other specialists
- Sensitization of judiciary to prevent further admissions under the Indian Lunacy Act.
- Filling up of vacancies.

### **Suggestions for the State**

Despite being the eleventh largest state in the country, Tamil Nadu has only one government psychiatric facility for the entire state. This in addition to making it inconvenient for patients from distant parts of the state contributes to chronicity and institutionalisation as many patients' families are simply too poor and cannot afford to stay with or visit the patients regularly. There is thus an urgent need to develop and strengthen alternative psychiatric services in the State. Many district units have psychiatrists. These need to be strengthened. There is a need for more psychiatric beds in general hospital psychiatric units and district hospitals. The District Mental Health Programme is being carried out in Trichy District and is in its second year. Awareness programs on mental health are being carried out in the State, but need to be increased to reduce the stigma associated with mental health and treatment of psychiatric disorders.



# CHAPTER-29

## UTTAR PRADESH

### INTRODUCTION

Uttar Pradesh is the most popular State in the country and ranks fourth in area. It covers about 9% of the area. It has hilly areas, plain lands and is a thickly populated state. Agriculture, industries, tourism, and business are the main sources of income. UP is the largest producer of food grains and oil seeds in the country and also the number one producer of wheat, maize, barley, gram, sugarcane and potatoes. Agro-based industries such as sugar, cotton, textiles, edible oils are also there. There are 83 districts with a population of 13.87 crores.

There are 8 medical colleges located at Meerut, Aligarh, Agra, Kanpur, Lucknow, Gorakhpur, Allahabad and Varanasi. There is one PHC for every 40,000 population. There are 3 mental hospitals one each at Agra, Bareilly and Varanasi. One of the oldest private psychiatric hospitals is Noor Manzil hospital at Lucknow. All the medical colleges have departments of psychiatry. King George Medical College hospital has one of the biggest general hospital psychiatric units in the country with a bed strength of 200. Practicing psychiatrists are also available in many cities and towns.

### AGRA MANASIK AROGYASALA, AGRA

#### Background

Agra lunatic asylum was established by the British Government in September 1859, and renamed as Mental Hospital, Agra in the year 1925. Initially the mental hospital was under the charge of the Inspector General (prisons). The first full time Medical Superintendent was appointed in 1905. The first full time psychiatrist in-charge was subsequently appointed in 1911. In 1985 the hospital was renamed as Agra Manasik Arogyasala, Agra. In 1995 it was declared as an autonomous institution being governed by the Management Committee after the Hon'ble Supreme Court orders.

#### Infrastrucute

The original architecture of the hospital had close proximity to that of a jail. Later on open ward system was adopted. The family wards were started in 1997. The hospital is in a transition phase though the old concept is still prevailing. The hospi-



tal has a land area of 175 acres. Hospital buildings are nearly seventy five years old and require extensive renovations. The hospital has a sanctioned bed strength of 718 (543 male & 175 female) and presently 447 patients are admitted in 22 open wards, 5 paying wards, and one building consisting of 30 rooms and 3 family wards.

### **Admissions and discharges**

Since 1993 admissions and discharges are governed under the provisions of the Mental Health Act, 1987. Only five percent of the admissions are voluntary and the rest are involuntary (through the Courts). Nearly fifty percent of the patients are staying for more than two years.

### **Staffing pattern**

There is one Director, one Medical Superintendent and two senior medical officers. Five ordinary grade medical officers are also posted. In all, services of seven psychiatrists are available for the entire hospital. There is one clinical psychologist since one year and he carries out psychological evaluation and counseling of family members of indoor patients. There is a psychiatric social scientist and psychiatric social workers who carries out the social work component of mental health services in the hospital. It is reported that they have a staff training program for medical staff, nursing staff and non medical mental health staff carried out once a month. There is a motivation in the staff. At present there are two sisters and fifteen staff nurses. The nursing staff work in three shifts and the nurse patient ratio is 1: 225.

## **SERVICES**

### **Casualty and emergency service**

There is a casualty and emergency service present and is easily accessible. Five to six patients report to the casualty every week. Out of them seventy to eighty percent are treated as outpatients. There is one roadworthy ambulance. Facilities in the casualty are inadequate. Infrastructure, staff and equipment need improvement.

### **Outpatient service**

The outpatient services function in a separate block from 8.00 a.m. to 2.00 p.m. daily. On an average 35-45 new cases, 3 to 5 emergency cases and 3 to 4 patients brought with chain. There is a waiting hall for the patients which will accommodate only 50% of the patients. The seating arrangements are poor. There are no free drugs for the OPD patients. The hospital provides modified ECT for patients and charges Rs. 35/= for each ECT given. There are no facilities for laboratory investigation in the OPD.



## Inpatient services

Each patient is provided with a steel cot, mattress, thin white sheet and a pillow. Most of the white sheets were brand new. In winter, blankets, razai and brown woollen overcoats are provided to the patients. In summer, each patient is given a cotton kurta and pajama as the hospital dress. Some patients are encouraged to use their own clothes. Few patients did not have bedding, mattress and pillows. The sheet and dress are changed once a week. The patients lack privacy in the wards. Some patients' clothes were dirty and torn.

Though the toilet facilities are provided, it is inadequate. Some toilets have no water taps and bathing facilities are poor. There are no mugs, buckets in the bathrooms or toilets. Each ward has 20 to 30 patients. Each ward is quite a distance from the other. There is no intercom / telephone connection between the wards. The family ward is more than 1 km away from the administrative building. It is not possible to reach this ward without the assistance of a vehicle.

There is no facility to safeguard the patient's belongings. There are two barbers for shaving heads of female patients and haircut and shave for male patients, but the facilities are inadequate. All the single rooms with iron doors have been converted to store rooms and patients do not stay there.

The visiting time for patient's relative is 11 a.m. but the hospital had put up a board that said, "No visitors are allowed". The board asked to be removed by the visiting team. The female and male wards are quite distant from each other and there is no mixing of male and female patients. The female patient's wards are in a separate compound and the main door is always kept locked with a female chowkidar at the door. Only hospital staff is allowed to enter. When family members wish to meet a patient, a meeting is arranged at the entrance of the gate.

The lighting within the wards and in the compound is poor, with only one or two bulbs in each ward and attached to the poles in the compound. In a few wards there are loose wires hanging. The attenders use a long lathi to control the patients and often gets beaten up. The female and male wards are still called "infirmary". The patients complained that no assistance is provided to them to write letters to their family members. Only inpatients are provided with free drugs.

The inpatients are served breakfast of pulses and tea around 7.30 am. Around 11.00 am 40 to 50 patients are made to sit in rows and lunch is served. Each patient is provided with a steel plate, a bowl and a tumbler. The lunch comprises of chappati, curry and dhal. The quantity and quality of food served is adequate. In the evening dinner is served around 6p.m. In all 5 to 6 patient groups are made at different



locations in the hospital for serving the food. Occasionally rice is served. The ward attenders serve the food. There is a kitchen, which is fairly well maintained though it is an old building. There is gas provided for cooking.

## **Legal issues**

Based on a public interest litigation the Supreme Court had ordered that this Institution be converted into an autonomous body.

## **Suggestions**

Despite the fact that the hospital has been made an autonomous institute changes are yet to take place.

- There is an urgent need to improve the staff strength of psychiatrists and other support staff.
- Free drugs to be provided for deserving patients attending the outpatient facility.
- The buildings need to be repaired and the basic facilities need to be improved.
- The psychiatric care of the patients and facilities for treatment like rehabilitation services need to be started.
- It is better to increase the open ward and family ward facilities so that relatives may stay with the patients.
- Improvement in the living conditions like, sanitation, regular water supply is needed.
- Provision of recreational facilities apart from television is required in the wards.
- Provisions for modern methods of record keeping and data retrieval is needed.
- There is a need for establishment of full-fledged Engineering Department under the control of the Management Committee or the Medical Superintendent.

## **MENTAL HOSPITAL, BAREILLY**

### **Background**

It was established in 1862 as a mental asylum and subsequently the name was changed to mental hospital. It is located 0.5 kilometers away from the city center.



## **Infrastructure**

It has a jail type of architecture. It has bed strength of 408 of which 296 is for men and 112 for women. Of the total 156 patients are staying for more than two years. Among this a large proportion are men. There is no separate beds for children. There are 7 closed wards. There are 34 single cells, which are still being used. They remain locked up all the time. At the time of visit there were 310 patients in the hospital. No family members are allowed to stay or even visit the patients freely. Most of the admissions are involuntary. The average duration of stay is 2 years. The buildings are reasonably well maintained except for some that need to be demolished.

## **Finance**

There is no plan budget for developmental activities. Out of the budget provided 65% is spent on salary, 3% on drugs, 1.7% on linen, 12% on food and 4% for maintenance. There has been no increase in budget since 1996 resulting in deterioration of quality of service. There is an urgent need to improve the overall budgetary provisions. Budget allocations for drugs and linen need immediate attention.

## **Staff**

The Medical Superintendent is not a psychiatrist. There are two psychiatrists and four general medical officers. There are no posts of clinical psychologists, Psychiatric Social workers, Psychiatric Nurses, or occupational therapists. Surprisingly there is not a single nurse posted in the hospital or nurses posts. Male attenders are 56 in number and female attenders are 23. The working hours is 8 am to 2 pm.

## **SERVICES**

### **Casualty and emergency**

There are no casualty and emergency services provided. However, for medical emergencies for the inpatients an ambulance is provided to shift them to general hospital.

### **Outpatient services**

The outpatient services were started a few years ago. It works daily between 9 a.m. to 1 p.m. 10-30 patients are seen here daily. Two doctors take turns to attend the outpatient department. No free drugs are given. There are no laboratory facilities for basic investigations. Rupees two is charged for registration and rupees twenty five for ECT. There are four interview rooms in the outpatient. There is no services of the psychologists, psychiatric social worker and nurse. Poor record keeping is observed in the outpatient department.



## **Inpatient services**

Most of the time the inpatients are locked up and they cannot move freely. The cells and wards are opened between six and seven in the morning and again they are locked up at eleven o'clock in the morning. It is again opens at three thirty in the afternoon. After dinner they are again locked up. Dresses are provided as white pajama and shirt for men and gowns for women. The toilets are inadequate in the ratio of 1 for 30 patients. They are badly maintained and there is no running water. Direct ECT is given, as there is no anesthetist available. There is no separate washing place. Medical records are poorly maintained and files are not retrievable. The medical records section is looked after by an improved patient who is working as a clerk. This hospital is one of the poorest in terms of patient care which needs improvement in all areas.

There are no recreational activities in the wards. Few patients are allowed to work in the garden. The basic facilities like toilets, linen, water, electricity supply to the wards are very poor. The relatives are allowed to visit the patients once in a week on Wednesdays near the administrative block. Food is prepared using firewood. There is no dietician. The staff position in the pantry is inadequate. Food is served in the verandah of the wards. There has been frequent complaints regarding food supplied.

No laboratory and psychosocial investigations are done. There is no post of Laboratory Technician. There is no rehabilitation services available for the patients. A few patients are allowed to work in the garden. A few students from the university (applied clinical psychology, Ayurvedic Medicine, Nursing Students from mission hospitals) visit the hospital. There is no formal training. There is no involvement of NGOs or volunteers.

## **Community services**

There is no community services or other training programmes for the non mental health professionals.

## **Legal issues**

The Mental Health Act, 1987 is partially complied. The Board of Visitors meet once a month. The Judiciary not being aware of the Mental Health Act, 1987 continue to admit children and persons with mental subnormalty to the mental hospital.

## **Summary**

This hospital is one of the poorest in terms of patient care. Outpatient services, living conditions, supportive services like kitchen, laundry, rehabilitation and recreational facilities are very poor.



## **Suggestions**

- Living conditions of the patients inside the hospital should be improved immediately.
- Single cells should be abolished.
- Hospital should be opened up with family members being allowed to stay with the patient.
- The Medical Superintendent should be a psychiatrist.
- Modified ECTs should be given to the patient.
- Creation of posts of psychologists, social worker, nurses is an urgent requirement.
- Establishment of rehabilitation and recreational services with infrastructure, staff and equipment is a must for the patients in the hospital.
- There is an urgent need to improve the overall budgetary provisions.
- Establishment of clinical laboratory with infrastructure, equipment and staff.
- There is a need to establish a separate x-ray and EEG department with staff and infrastructure.
- Supportive services like kitchen, laundry, medical records need to be developed.

## **MENTAL HOSPITAL, VARANASI**

### **Background**

It was established in 1809. It is located 5 kms away from city center. It is being used to house psychiatric patients with criminal records. It looks and functions like a jail with high walls, guarded entry and no visitors allowed inside the hospital. Every person, who enters, has to sign a register. Even today it is called a lunatic asylum ('pagal khana'). It caters to entire Uttar Pradesh and Himachal Pradesh.

### **Infrastructure**

It resembles like a jail. There are two closed wards, rest are barracks and cells. It has a bed strength of 331 out of which 252 are for men and 79 for women. At present it houses 270 patients.

### **Staffing pattern**

The medical superintendent is not a psychiatrist. Two qualified psychiatrists, one medical officer, and 56 attenders are the other staff members. There is no nurse,



clinical psychologist, psychiatric social worker, occupational therapist available. There are no posts present. The working hours of the staff are from 8am to 2 pm. No doctors are available for help after 2 pm.

## **Finance**

There is no plan budget for the development activities. Out of the available budget, 60% is spent on salaries, 3.7% on drugs, 1.82% for linen, 16.8% for food, 9.8% for maintenance. The financial allocation to the hospital is inadequate and needs improvement specially in the area of drugs and linen and needs immediate attention.

## **SERVICES**

### **Casualty and emergency service**

There is no casualty and emergency services. There is no ambulance available.

### **Outpatient service**

There is a regular daily outpatient services between 8 a.m. and 2 p.m. Ten to twenty patients attend the out patient daily. The waiting hall could accomadate 50% of the patient. There are no investigatory facility. Free drugs are given. Staff in the outpatient is inadequate. There are no basic amenities in the outpatient department. There is no interview room in the outpatient department. Rupees two is charged for registration.

### **Inpatient service**

The wards are separate for male and female patients. Patients and family members have to undergo security when they enter through the guarded gates. Separate 'jungy' wards are built like Jail barracks to house 'Criminal ' patients. Single cells have no basic facilities. A few buildings have fallen down. All the patients are admitted through the court. Two thirds of the patients admitted through the court do not have any criminal background. The other one third admitted through the court have a criminal record. These two groups are mixed up. Every patient is looked at as if he is dangerous and a potential candidate to escape. When a patient is brought in, he is kept in a single cell, without medicines and locked up, for 2 weeks. These cells are small enclosures without light, water, bed, linen and toilet. Food plates are pushed into the cell or kept near the door. The patients are treated like caged animals. The wards are built like jail barracks. 20 to 30 patients stay in each ward. There is no bed, no linen and there are 4 toilets with no privacy for each barrack. There are no water facilities. The wards are very badly maintained. Patients live in, inhuman conditions. One hundred men and twenty five women are staying for more than two years.



The kitchen is in a bad shape. There is only one cook. Some patients work in the kitchen. Firewood is used. Quantity and quality of food is very poor. Food is served in the corridors. Rs. 12/- per day per patient is the expense on food. Patients bathe under taps in the open. There is no privacy for patients and uniforms are torn and dirty.

Some family members visit their patients. They are allowed to see the patient once a week (visitors' day) in a safe enclosure. Majority of the patients are not visited by any body. There is no communication between the patients and their family members. Undertrial patients cannot attend the court as police escort is not available on most occasions. They remain here for years, or life long. No X-ray and EEG facilities are present for the entire hospital.

As 2 doctors have to manage 270 patients, individual attention cannot be given. Many patients get very low dose of drugs (just 50 or 100 mg of chlorpromazine). Physical ailments are neglected as there is no provision to get the physicians from other hospital or to send the patient to other general hospitals. Case records are highly inadequate and cannot be retrieved. Direct ECT is given. A few patients are allowed to work in kitchen or gardens. Majority of the patients remain locked up in their wards and are made to sit / lie down idly. There is no phone or ambulance.

### **Community services**

There is no community services or any other rehabilitation services in the hospital.

### **Legal issues**

Reportedly Mental Health Act, 1987 is complied with. The Board of Visitors meet once or twice a year.

### **Summary**

The conditions in the mental hospital is quite bad and need immediate change and improvement. It is deplorable that there are no nurses in the hospitals and no activity goes on here. The infrastructure is not suitable for living and the patients are denied of their basic rights. Relatives must be permitted to visit and patients must not be locked up. The number of psychiatrists and other support staff needs to be increased immediately.

### **Suggestions**

- Living conditions of the patients inside the hospital should be improved immediately.
- Single cells should be abolished.



- Hospital should be opened up with family members being allowed to stay with the patient.
- The Medical Superintendent should be a psychiatrist.
- Modified ECTs should be given to the patient.
- Creation of posts of psychologists, social worker, nurses is an urgent requirement.
- Establishment of rehabilitation and recreational services with infrastructure, staff and equipment is a must for the patients in the hospital.
- There is an urgent need to improve the overall budgetary provisions.
- Establishment of clinical laboratory with infrastructure, equipment and staff.
- There is a need to establish a separate x-ray and EEG department with staff and infrastructure.
- Supportive services like kitchen, laundry, medical records need to be developed.

### **Suggestions for Uttar Pradesh**

Although there are 3 government mental hospitals in UP, all the three are not up to the mark in providing quality care to the mentally ill patients. Immediate action needs to be taken in the following areas:

- Shift from custodial to therapeutic centers.
- Immediate recruitment of nurses at Bareilly and Varanasi.
- Creation of posts of Clinical Psychologists, Nurses and Social Workers at both Bareilly and Varanasi
- Proper monitoring of patients by the medical personnel, and better record maintenance. Running of regular OPD services, especially at Varanasi
- Security to be provided by the jail authorities for the criminal mentally ill at the hospital. All the patients in Varanasi are confined because of the fear of escape of the group
- Sensitization and training of all levels of hospital staff
- Sensitization of the judiciary.
- Liaison with other hospitals to provide physical care. Facilities such as ambulance and telephone to improve communication with outside agencies.



# CHAPTER-30

## WEST BENGAL

### INTRODUCTION

The State of West Bengal has an area of 88,752sqkm. There are 19 districts and Calcutta is the capital. The population is 68 million with 35 million males and 33 million females. There are 917 females for every 1000 males. The density of population is 766 persons/sqkm with an urban population of Rs. 27.5%. The literacy rate is 57.7% and per capita income is Rs. 3963.

There are 6 mental hospitals in West Bengal, out of which 3 are situated in Calcutta, 1 is in Hooghly, 1 in Murshidabad and 1 in Purulia. The first four hospitals are close together near Calcutta while the one in Murshidabad is about 5 to 6 hours by road or rail from the Capital. Purulia is about 2 hours from Ranchi, Bihar State and the hospital here is the newest in India established in 1994. There are also hospital beds managed by some private psychiatric hospitals and NGOs' working with the mentally ill. Some of these NGOs' are recognised by the courts and the Government and magistrates send even involuntary and legal admissions there. This is because the conditions in most of the Government hospitals are thought to be very poor. There was a historic public interest litigation filed a few years ago followed by an enquiry after which some changes have occurred.

### INSTITUTE OF PSYCHIATRY, CALCUTTA

#### Background

This is the third oldest mental hospital in India, which was established in the year 1817. This was called the European Lunatic Asylum/Mental Observation Ward. It was initially a private hospital owned by Mr. I. Beardsmore. In 1856, this was taken over by the East India Company administration and Dr.J.Cantor was appointed as the first Medical Superintendent. In 1924, this was re-named as Bhowanipore Mental Observation Ward. In 1963, outpatient services were started in this hospital. In 1989, it was declared as a teaching hospital. In 1991, it was re-named as Institute of Psychiatry. This hospital is situated inside the campus of Institute of Postgraduate Medical Education and Research, SSKM General Hospital.

#### Hospital infrastructure

The majority of buildings are old. One new building is there which has been converted into a teaching and training facility and record room. There are only



closed wards. All the patients pay for services. There is a separate alcohol and drug abuse ward with six beds. In the general category, facilities like drinking water, bath taps and toilets are available. As all the patients are in the paying category, there is no difference between general and paying patients. Total bed strength is 36 including 6 beds for de-addiction. Buildings are not properly maintained. It is a Government building maintained by the Department of Public Works. Facilities like electricity, telephone, and library are adequate. However, water supply is inadequate and drainage has to be improved.

### **Staffing Pattern**

There are no qualified psychiatrists as part of the mental hospital. However, the Professor of Psychiatry, along with two other psychiatrists, is posted from the Medical College. There is 1 clinical psychologist, 1 trained psychiatric nurse, 10 general nurses and supportive staff. Superintendent, nursing staff and a pharmacist stay in the campus. The working hours of the doctors is for 8 hours. All the ward staff are not trained in mental health and staff structure is highly inadequate. There are regular staff meetings once in a month of the staff and once in a week with all the doctors. There is some amount of amotivation in the staff due to absence of training, poor work culture and monotony of the job. Remedial measures have been suggested by the staff members.

### **Finance**

No fixed budget is allocated for the hospital. Money is given from time to time depending on the requirement. Donations are not received in cash or kind.

### **Admissions and Discharges**

Admissions are court directed cases and voluntary admissions. All the admissions are made by the psychiatrists. The duration of stay for a patient is 4-6 weeks. There are currently 3 long staying patients who are there for more than two years. Admissions and discharges have been stopped for the past 6 months due to non-availability of ward attenders. There were a large number of ward attenders present in the hospital. Following a suicide, they were suspended and no replacements have been given. Hence all inpatient admissions have been temporarily closed. However, the outpatient services are functioning as usual. De-certification is done by the hospital authorities. Discharge problems are being faced because of the poor family support. No liaison is present with the police department. Patients are informed of their rights and they have a right to appeal.

### **Finance**

No fixed budget is allocated for the hospital. Money is given from time to time depending on the requirement. Donations are not received in cash or kind.



## **SERVICES**

### **Casualty and emergency service**

Casualty and emergency services are absent.

### **Outpatient services**

Outpatient services are present. Outpatient is conducted daily from 8 a.m. to 3 p.m. Approximately 15 new patients and 125 old registrations come for consultation. About 5 - 6 patients are brought either chained or roped. There are adequate number of interview rooms (5) in the outpatient. There is a waiting hall for the patients with seating arrangements that are in fairly good condition. Very few patients are given free drugs. Facilities in the outpatient are reported as inadequate. As they have no trained staff, administrative staff and proper facilities in the outpatient.

### **Inpatient service**

The inpatient wards are cleaned once in a fortnight. There is no daily activity program for patients and most of the time the patients spend time idly. Patients are given bath daily. Dress change is done daily and linen is changed once in a week. There is adequate stock of cots, mattresses, linen, pillows and blankets. Patients are allowed to wear their own dress. The ratio of toilet to patients is 2:1. All the other facilities are adequate. There is no privacy for the patients. Some indoor recreational activities are provided like the television and carom board which are extremely inadequate. There is no facility to keep patients' belongings. Record of menstruation is not maintained. Weight record is maintained. Shaving of the head is done for male patients and occasionally for female patients also. Shaving of the head once in a month and hair cut once in a week is done. There is a facility for providing inpatient emergency care. Quarterly, anti-lice measures are adopted; anti-mosquito measures are done using chemical methods. Only 10% of the patients, who are admitted by a court order, are free patients. The rest of the patients have to pay. There are single rooms with iron gates, which are used regularly. There is a duty room available inside the ward. As the buildings are old, the facilities are inadequate in the inpatient set up, and there is a need to change the buildings.

The Government provides Rs.10/- per patient for food, which is supplied by the Government contractors. The quality and quantity is very poor. From August 1998, the amount is increased to Rs.20/-. There is a kitchen supervisor who supervises the food preparation. Quality checks are done by the Resident Medical Officer. Free diet is given for all inpatients. There are water taps in the ward for drinking water. There is no water cooler. Food is supplied by hand pulled trolleys in closed containers. Firewood is used for cooking. The kitchen needs to be more hygienically main-



tained. Food is served in plates and cups in the dining hall and there are complaints about the quality and quantity of food supplied. Food supplied is overall unsatisfactory.

Routine investigations are present. Special investigations like lithium estimation are there. X-rays, EEG and other HIV screening and Hepatitis B are not done. Cognitive functions and diagnostic psychological tests are done. Routine investigations are not charged, however, special investigations are charged. This institute has many modern laboratory equipment but no laboratory technician. Hence these instruments are not used. There is a need to improve the structure and functioning of the hospital at the earliest.

No charges are levied for psychological assessment. There is facility for drug therapy and direct ECT's. Modified ECT's are not given, as there is no anaesthetist. Psychotherapy and psychological education are provided to the patients. For controlling violent patients, physical restrains, drugs and seclusion are used. Recreational programmes are inadequate. There is no rehabilitation program and no community based service. There is no liaison between NHS schools or any other specific agencies.

There are separate case files for each patient. Case files are maintained from 1965 and they are maintained as papers clipped together in box files for a group per year. Retrieval of files is done on request. Access of records is to the treating team and confidentiality of the files is maintained. As there is postgraduate training here, notes in the files are reasonably adequate. It was noticed that the postgraduate students who are coming to the mental hospital are motivated to improve the facilities.

### **Legal aspects and rights**

There is no Board of Management. It is reported that the rights of the patients are provided to all. However, on visiting it was found staff members are not fully aware of the rights. All patients are allowed to write letters to their houses. They are allowed to talk to recognised social agencies. There are efforts to sensitise the staff on the rights of the mentally ill. There are no public interest litigations or specific complaints against this hospital in the court.

### **Suggestions**

- Optimum manpower provision - both teaching and non-teaching categories.
- Construction of the total hospital building as per the proposed master plan.
- Additional support staff especially ward staff should be provided. They



should be trained to handle the mentally ill.

- Board of Visitors has to be constituted.
- Necessary action to be taken to revive the inpatient services.
- The Institute may be declared as an autonomous teaching hospital with a Director. Proper academic wing should be formed for postgraduate education (MD/DPM), Diploma in Psychiatric Nursing for nursing staff; teaching to other postgraduate students, physiotherapy students, B.Sc. nursing students etc. This Institute has the potential to develop as a regional psychiatric training centre for the whole region.

## **LUMBINI PARK HOSPITAL, CALCUTTA**

### **Background**

Lumbini Park Hospital was established in 1940 and is providing continuous service since then. It is situated 3km away from the city centre. This hospital was developed by the Indian Psychoanalytic Society. In 1994, the Government of West Bengal took over the hospital. The name “Lumbini Park” means a place of tranquillity. Patients from Calcutta and suburban areas avail the services of this hospital

### **Infrastructure**

This hospital is like a general hospital with open and closed wards in one single storied building. There are 2 pavilion type wards meant for males and females. No separate speciality sections are present. Total bed strength is 200. Male and female bed strength is not separately earmarked. Buildings are old but reasonably maintained. The buildings are totally owned by the Government of West Bengal. It is maintained by the Public Works Department. Water supply and electricity are adequate.

### **Staffing**

There are 6 posts of psychiatrists with one post remaining vacant. There are no general medical officers. The rest of the staff consists of 1 clinical psychologist, 2 trained psychiatric nurses, 18 general nurses, 46 ward attenders and 36 safaiwallas. In addition, there is 1 librarian, 1 driver and 11 office staff. Services of visiting consultants are not present. Accommodation for staff members in the campus is not available. Inadequacy in staff in terms of less psychiatric social workers, clinical psychologists and psychiatric nurses are there. The timings for the doctors are from 8.30 a.m. to 1.30 p.m. with evening rounds twice a week. Doctors and nurses participate in training programs occasionally. There are regular monthly meetings for the staff members. Occasional in-service training is conducted for the staff. There is burn out in about 30% of the staff.



## **Admission and discharge**

A government screening board does admissions of patients. Occasionally emergency cases are admitted by psychiatrists and courts. Mental Health Act, 1997 is followed only in part in this hospital. Rights of the patients are told to them if they are in a position to understand. On an average, 81 patients are admitted as voluntary admissions and 50 patients admitted as involuntary in one year. Over the past few years there is an increase in admissions and discharges. Fourteen deaths have been reported in the last 5 years, out of which 4 patients committed suicide. There are 32 patients staying in the hospital for more than 2 years. Average duration of inpatient stay is 6 months. Majority (80%) of the admissions is repeat admissions. The main problem with discharge is that the relatives are unwilling to take the patient back home. Those patients who are admitted have the right to appeal.

## **Finances**

Budgetary provisions are adequate.

## **SERVICES**

### **Casualty and emergency service**

There is no casualty or emergency facility in this hospital.

### **Outpatient service**

Out patient services are on a daily basis. Facilities in the OPD are inadequate. Free medicines are available for all patients.

### **Inpatient service**

In patient services are fairly average with dormitory type wards. Patients can wear their own clothes, with daily cleaning and bath for patients. Cots and mattresses are adequate. The ratio of patient to toilets is 1:8, fans 1:9 and beds 1:1. Privacy for patients is absent. Recreational facility is provided in the ward in the form of carom board, playing cards and newspapers. There is a library for the patients. Every patient has facility to keep his belongings. Records of menstruation and weight are maintained. Shaving of head is not done for both males and females. Anti lice measures are done quarterly. Mosquito nets are provided. All patients are of the non-paying category. There are no seclusion wards. The cost of the diet per day is Rs.22/- for all inpatients. One psychiatrist is in charge of the kitchen. Seasonal fruits are provided for the patients. Facility for drinking water is provided in the wards. Food is served in closed containers. There are reports by the patients and the staff that the taste of the food is not very good.



Investigation facilities are not present in this hospital. For all the investigations including routine, patients are sent to the medical college hospital. Drug therapy and direct ECTs are provided regularly. Violent patients are controlled using drug therapy. Physical restraints are not used. Rarely psychological tests are done. Occasionally patients who need are given psychotherapy.

Medical records are maintained in the form of papers stapled together. Case notes are inadequate. There is no involvement of volunteers in this hospital. There are no facilities for rehabilitation or for community services. There is no library facility for staff in this hospital.

### **Legal aspects and rights**

Board of Management has been constituted. There was no litigation against this hospital. However, the High Court of Calcutta has given some directives for improvement of services. Rights of the mentally ill are known to only few of the staff.

### **Suggestions**

The visit to this hospital revealed that the office staff occupies a large area of space. There are posters of various trade unions inside the hospital and the walls look very shabby. Because of the excessive union activity, the relationship among the staff members is not very cordial. This hospital needs a larger space, minimum basic facilities, rehabilitation programs, and provision of additional mental health professionals. There is a need to improve the variety and taste of food.

- Hospital should have more space in terms of building and campus.
- There should be adequately maintained garden.
- Visitors' annex should be constructed for patients' relatives.
- There should be adequate number of trained paraprofessionals.
- Rehabilitation facility has to be started.
- Doctors and nurses should interact with patients more frequently.
- Patients should be encouraged to voice their grievances.
- A confidence building atmosphere should be constructed by all kinds of staff.

## **PAVLOV HOSPITAL, CALCUTTA**

### **Background**

Pavlov Hospital, Calcutta was established in 1966. Previously, it was known as Albert Victor Leper Hospital, and the original name was Hospital for Mental



Disease, re-named as Pavlov Hospital in September 1985. From 1996 it is owned and managed by the Government of West Bengal.

## **Hospital infrastructure**

This hospital has a two storied building, which is 105 years old. It is very near to the general hospital. There are only closed wards. Total bed strength is 250 out of which 129 is for males, 111 for females and 10 for substance abuse. Buildings are reasonably maintained. It is a government building maintained by the Department of Public Works. A notable feature worth emulating by other hospitals is that there is an engineering department in the hospital with an Asst. Executive Engineer posted full time.

## **Staffing pattern**

There are 7 qualified psychiatrists, 2 General Duty Medical Officers, 3 clinical psychologists, 2 medical social workers, 1 lab technician, 2 radiographers, 33 general nurses and 4 ward masters. The Medical Superintendent is a non-psychiatric physician, but is aware and sensitive of needs of psychiatric patients. It is reported that working hours of the doctors is for 5 hours and for other staff 8 hours. All the staff are not qualified for their jobs (there are no psychiatric nurses or trained attenders) and staff strength is inadequate.

## **Admissions and Discharges**

Admissions are court directed cases and by voluntary admissions. All the admissions are done by the psychiatrists and judiciary. They have difficulty in discharging patients sent by judiciary. On an average, there are 10 deaths per year and 2-3 suicides per year. Patients are informed of their rights. More than 50% of the long stay patients have stayed for two years or more. Average duration of patient's stay in this hospital is 3 years. Decertification is done by the hospital authorities. Problems are faced in discharge because of poor family support. Efforts have been made to take assistance from parents and relatives. There is no liaison with the police department. Patients have a right to appeal. Budgetary allocation is reportedly adequate.

## **SERVICES**

### **Casualty and emergency service**

Casualty and emergency services are absent.

### **Outpatient service**

Outpatient services are present daily from 9 a.m. to 2 p.m. Approximately 13 new cases and 300 old registrations are seen. About 3 - 4 patients are brought chained



or roped. All the medical officers and psychiatrists participate in outpatient services along with clinical psychologists. There is a waiting hall for the patients with seating arrangements, which are in good condition. All the patients are given free drugs. Facilities for the outpatient are reportedly inadequate. There is scope for improvement in the overall situation.

### **Inpatient services**

The inpatient wards are cleaned once in 2-3 days. Patients are given daily bath. Dress change is done daily and linen is changed once in a week. Pillows are not supplied. They have sufficient stock of cots, mattresses, linen and blankets. 2 pairs of uniforms are given to male and female patients. Ratio of cots to patients is 1:1, ratio of fans 1:20 and toilets 1:15 patients. Privacy for the patients is not present. There are facilities for keeping belongings. Indoor recreational programs are present but not adequate. Record of menstruation and weight is maintained. Shaving of the head is done once in a month and hair cut once in 3 days. There is provision for providing inpatient emergency care. Anti-lice and anti-mosquito measures are done using chemical repellents. There are no paying patients. Seclusion wards are present and used occasionally. Duty rooms are present inside the wards. Visitors are allowed during visiting hours. Facilities in the inpatients are inadequate.

The Government gives Rs 20/- per patient for food and the government contractors supply this since June 1998. There is no facility for telephones, water cooler, sufficient soaps, and towels. One of the group 'D' staff supervises the food preparation. Quality checks are done by the Medical Officer. Free diet is given to all inpatients. There are taps inside the ward for drinking purposes. Food is supplied by hand pulled trolleys in closed containers. Firewood is used for cooking. Hygiene is good. Food is served in plates and cups in the dining hall and there are occasional complaints about the quality and quantity of food supplied. No rehabilitation facilities are there. There is an NGO called Paripurnatha, which works for the patients' rehabilitation. This is not adequate as they can take care of only few patients.

Routine haematological investigations are not present. There is facility for X-rays. Psychological and sociological assessments are made and no charges are levied for these tests. There is facility for drug therapy, direct ECTs. Modified ECTs are given occasionally. Behavioural therapy facility is also there. Once in a while the hospital takes patients for outside programs. The authorities have submitted a proposal for a rehabilitation facility that is yet to be sanctioned. There is no community service or staff training.

### **Medical Records**

There are separate case files for each patient. Case files are maintained since the inception of the hospital. Retrieval of files is done on request and access is re-



stricted to the treating team only. The notes in the files are inadequate.

## **Rights of Patients**

It was reported that information on the rights of patients was provided to some of them. Efforts have been made to sensitize the staff on the rights of the mentally ill. Family members are not allowed to stay in the wards. All patients are allowed to write letters to their homes. They are allowed to talk to recognized social agencies. There is no liaison with the NSS or other volunteers. No court representations against the hospital were found.

## **Suggestions**

The staff members have suggested that a rehabilitation facility is started and investigation facilities should be improved. They felt the need for staff training and to develop this into a training institute. A specific request was to separate the hospital campus from the residential quarters of the staff, as the relatives of patients were creating a nuisance in this campus. As observed during the visit, this was the best hospital in the state of West Bengal. It has a good liaison with the medical college hospital. There was a reasonable amount of cleanliness with well maintained buildings. The patients did not have any complaints. The immediate need is the development of a rehabilitation facility.

## **MENTAL HOSPITAL, CALCUTTA & MANKUNDU, HOOGHLY DISTRICT**

### **Background**

This hospital was established in the year 1932. The original name of the hospital was Mental Health Centre, Calcutta. This hospital was run by the Court of Governors and presently run by the Administrator, SDMO, Chandan Nagar, Hooghly, appointed by the Government of West Bengal since 1982. This hospital had Indian Superintendents since establishment. This hospital was shifted from Calcutta to Mankundu in 1940. The authorities consider this as a private hospital run by the financial help from the paying patients admitted in the hospital along with contributions from various government bodies. There are 180 beds.

This hospital does not come under the Directorate of Health. However for the analysis it is treated along with the government facilities as a large number of beds are sponsored by the government funds and administration is by the administrator appointed by the government.

### **Infrastructure**

Hospital buildings are generally in a very bad condition. There are only closed



wards. There is a children's ward, alcohol and drug ward, criminal ward, isolation ward, and chronic ward. The outpatient facility runs every day. All the patients get uniforms. The total bed strength is 180 of which 110 is for males and 70 for females. The administrator has overall charge of the hospital. Doctors are appointed by the Medical officer in the clinical side and the Supervisor is appointed for the administrative side. Buildings are not maintained properly. It is a private building donated by a family for running the hospital. The hospital authority is responsible for the maintenance of the hospital but they do not have adequate funds. The hospital does not have an intensive care unit, ambulance or any major equipment. Water and electricity facilities are adequate.

### **Staffing pattern**

There are 3 qualified psychiatrists, 1 General Medical Officer, 27 Nurses, 2 Occupational Therapists and 27 Attenders. There are 9 administrative staff, 1 cook and 9 sweepers. There are 36 staff members who stay in the campus. Currently, staff strength is adequate. The pay scales of the staff are very low ranging from Rs.800/- for the sweepers to Rs.1000/- for the psychiatrists. Working hours of the doctors are 3 hours a day.

### **Finances**

Budget allocation of funds to the hospital is not available in any of the records. Separate accounts are not maintained for various funds. This hospital is running with the available payment given by the patients as well as corporation and government sources and there is a financial crisis at present. The hospital receives the bed charges from the Government of West Bengal (60 beds @ Rs 7000/- per year), Calcutta Corporation (20 beds @ Rs 650/- per month), Hooghly Zilla Parishad (4 beds @ Rs 600/-per month), Hooghly Chinsurah Municipality (1 bed @ Rs 1000/-per month), Chandan Nagar Municipality (2 beds @ Rs 800/-per month), Bhadreswar municipality (2 beds @ Rs 800/-per month), Rishra Municipality (2 beds @ Rs 800/-per month), Electricity Board (2 Beds @ Rs 1500/-per month), Free Beds (5), Paying beds (82 @ Rs 1500/-per month) The Charges are per bed.

### **Admission and Discharge**

The Indian Lunacy Act of 1912 is still being followed. All the admissions and discharges are done through the outpatient. Admitting authority is the psychiatrists. No records are maintained. Due to this the duration of hospital stay of the patients is not definite. The staff members say that approximately, the duration of stay is for 6 months. The proportion of repeat admissions and reasons for this is not known. Usually help of the police for discharge is not solicited. The staff does not do anything for those patients who stay back in the hospital. In case of grievances, patients have a right to appeal.



## **SERVICES**

### **Casualty and emergency service**

Casualty and emergency services are absent.

### **Outpatient service**

Outpatient services are present daily from 10 a.m. to 1 p.m. About 20 - 70 patients attend the outpatient per day. 10 - 15 minutes is spent on an average with every patient. There is a waiting hall for the patients. No free drugs are provided. They charge a registration fee of Rs.10/-. Facilities in the outpatient are inadequate.

### **Inpatient services**

Cleaning of the wards is reported on a daily basis. It is reported that patients are given bath daily, daily dress changes take place, and daily linen change is there. However, on inspection, it was noticed that the overall premises and the condition of the patients in these wards were very poor. All the patients are allowed to wear their own clothes. There are 180 mattresses and pillows equalling the number of beds and none in the stocks. Recreational facilities are provided in the wards. They do maintain records of menstruation and weight. Hair cut and face shaving of the patients is done but frequency is not known. Anti-lice measures are used quarterly. All the patients have to pay.

The cook and assistant are in charge of the food and the kitchen supervisor checks the quality of the food. No free diet is provided. Food is served using a hand pulled trolley. Food supply is adequate but there is no separate dining hall. Very few investigations are done in this hospital. Majority of the tests are not done. Modified ECTs are given. There is no library facility and patients have access to one newspaper. Recreation is in terms of singing, playing carom, volleyball and watching T.V. It was reported that there was a daily routine in the wards. However, on spot inspection, it was found that this was not the case. Some of the patients are used for routine hospital work but they are not paid. Otherwise there is no rehabilitation activity. There are no community services, no training program for staff, no court representations and orders. No volunteers are involved. The adequacy of care is not very good.

### **Rights and Legal issues**

There are separate case files for each patient. Confidentiality is maintained. A few patients are allowed to write letters to their homes. Even though it was reported that the staff is aware of the rights of the mentally ill, on enquiry, it was found that they were not. There is an advisory committee of the West Bengal government. There is a Board of Visitors consisting of the Municipality Chairman of Bhadreswar.



Board of Visitors meet once or twice in a year. Mental Health Act is not complied with, rather the ILA, 1912 is followed.

## **Suggestions**

The public is having the opinion that this hospital has to be taken up by the Government of West Bengal and developed into a fully fledged one. It was brought to the notice of the team that this private hospital is managed by the administrator appointed by the Government of West Bengal.

Historically, a committee of private people ran this hospital. At present it seems neither the private persons, administration nor the government is interested in this hospital. At the same time, it was observed that beds of this hospital are sponsored by Government of West Bengal, Calcutta Corporation, different Municipalities and the electricity board.

About 82 beds are totally paying beds and 5 beds are free. From this, it is evident that government money is coming into this hospital, as well as there is a need from the public to have this hospital. The staff members and nurses of this hospital are paid inadequately. However, they seem to be committed and interested in the patients. As things stand today, the patients admitted here are not having their rights protected because of the absence of proper administration. This indicates that there is a gross violation of the rights of the people and it is important for the state government of West Bengal to come forward to take initiative action either by closing down this hospital and shifting the hospital to other place or run with proper facilities. This is an urgent issue that has to be addressed immediately considering that 180 human beings are lodged in the buildings here along with the dedicated staff members.

## **BEHRAMPUR MENTAL HOSPITAL, MURSHIDABAD**

### **Background**

This mental hospital was a famous special jail. Many eminent political figures like Netaji Subhash Chandra Bose were imprisoned in this jail during the independence struggle. This jail was converted as a government mental hospital on 12.6.1980 without any major changes in the structure and has become one of the worst hospitals in our country. The catchment area for this hospital is Murshidabad District, North Bengal District and its adjoining areas. The present central jail is 1 km from this hospital and the general hospital half a km away. Food and medicines are given free of cost. The bed strength was 150 (75 for male patients and 75 for female patients) at the beginning, but it was increased to 230 with 114 for males and 116 for females with effect from 6.9.1998, after patients belonging to West Bengal were transferred here from Ranchi.



## **Hospital Infrastructure**

There are 4 closed wards and 1 chronic ward. The buildings are old and poorly maintained. Buildings are leaking and there is no substantial improvement in the structure from that of a jail. There are single cells, which are very poorly lit, ventilated and overcrowded with inadequate/ absent toilet facilities. Buildings are owned by the government and maintained by the Public Works Department. The compound walls are high with watchtowers. These watch towers are not used and can collapse at any time. There are open drains with stagnant water where mosquitoes breed. Poorly maintained buildings are not cleaned properly. All the wards are closed ones. There is open area around the hospital of another three acres, which is currently vacant. Electricity, drainage, water facility, canteen, telephones and library are highly inadequate or absent.

## **Staffing pattern**

There are 6 qualified Psychiatrists' posts present, out of which 5 posts are filled and 1 is vacant, Of the 7 Medical Officers posts, 2 are vacant. There are 35 General Nurses of which 3 are vacant. Psychiatric nurses are not present. There are 6 posts of Medical Social Workers of which 4 are filled and 2 are not filled. Two posts of Clinical Psychologists are vacant. There are 270 posts of ward attenders and peons of which 35 are vacant. Supportive staff like 4 Pharmacists, 5 Store Keepers, 4 Ward Masters, 2 Tailors, 4 Laboratory Technicians, and 7 Administrative Staff are filled. Visiting Consultants from the speciality of internal medicine and chest diseases are there. A large number of staff belonging to all categories resides in the campus. Staff is reportedly adequate. Doctors are working for 5 hours and they are on call for emergencies. Other staff is working for 8 hours. The social workers are made to do clerical jobs rather than to see the patients. There is no staff training programmes. Psychiatrists as well as the medical officers do not even attend professional conferences or CMEs and no facility is provided for them in updating their knowledge. The awareness among psychiatrists about modern techniques of treatment and rehabilitation is poor.

## **Finance**

Budget allocated for the hospital maintenance is inadequate.

## **Admission and discharge**

There are involuntary admissions through court and by the medical board all ratified by the health services (Writers' building). Patients are discharged and handed over to their relatives when recovered. The rights of voluntary patients are not known at the time of admission. Long stay patients are relatively few and the average duration of stay of patients is 60 days. The problems of discharge faced by the hospital



are mainly because of non co-operation of families. Police do not take responsibilities regarding discharge. Patients' relatives are informed through telegrams and letters once they recover. Patients have right to appeal in case of any grievances.

## **SERVICES**

### **Casualty and emergency service**

Casualty and emergency services are present which are accessible. Common types of cases, which come to the casualty, are relapse of psychoses. There is no short stay wards. There is no ambulance. Medicines are sufficient in the casualty. Telephone facilities are available.

### **Outpatient service**

Daily outpatient services from 8.30 a.m. to 1.30 p.m are present with an average of 200 patients per day. 1 Psychiatrist along with 4 Medical Officers manages the OPD by rotation. 2 Social Workers and 1 Nurse also participate in the outpatient activities. There is a waiting hall for the patients. Seating conditions are very poor. One week's free medicine supply is given for the outpatients.

### **Inpatient service**

Cleaning of the inpatient wards is carried out daily. Daily bath is given for the patients. Once in 2 days dresses are changed. The overall hygiene in the wards is very poor. It was with difficulty that the team visited all the wards and other facilities due to the unhygienic conditions prevailing in the wards. Human excreta was present on the floor in all the closed wards. Cots, mattresses, linen, pillows and ward cloths are inadequate. Patients sleep on bare broken cots if they get one. There are specific uniforms for males whereas females do not have a prescribed one.

It is reported that anti-lice and anti-bug measures are adopted quarterly. This does not seem to be the case in reality. All the wards are infested with lice, which has formed colonies on the walls. Medical officers report that this is a major problem, which they are facing. There are seclusion rooms present, which are used regularly. These rooms are the single cells of the former jail, which are not suitable for human occupation in the present state. Duty rooms are present in the wards. The specified visiting hours for relatives is 11 a.m. - 12 noon and 4 p.m. to 6 p.m. The inpatient facilities are highly pathetic, inhuman and inadequate.

There are recreational facilities in the wards like carom board, television and radio, which are inadequate and not properly supervised. Privacy is absent for the patients. Facilities for patients' belongings in the ward are on a sharing basis. Record of menstruation and weight is maintained. Shaving head of male patients is there



which is done once in a month. Inpatient emergency care provision is there.

Dietary and pantry facilities are present. They provide three meals per day with Rs.10/- per patient. It has been increased to Rs.20/- from August 1998. Food is supplied using hand pulled trolleys in closed containers. Mode of cooking is by firewood. Food is supplied in the veranda. There are complaints of the quantity and quality of the food. There is provision of taps inside the ward for water facilities.

Routine blood investigations and X-ray facilities are present. No other investigation facilities are available. Drug therapy and direct ECTs' are provided. Medicines and seclusion wards are used to control violent patients. Very few recreational activities are present for the patients here like television and carom board. Rehabilitation services and community services are absent. There is no collaboration with outside agencies.

### **Medical records**

There are no facilities for separate medical records. Case files are written on paper and maintained using paper clips. There are individual case records for every patient. The notes by the psychiatrists and medical officers are inadequate in all the case records. Patients' progress and condition are not entered. Only the medicine prescribed is entered and most of the case files record only "repeat all". It has been noticed that patients are getting the same medicines without any dosage titration for long periods. No information on side effects or improvement is mentioned. This hospital with adequate medical staff can actually maintain good records, which are essential. Confidentiality of the case files is maintained. There are complaints regarding proper maintenance of records.

### **Rights and Legal aspects**

The rights of the mentally ill are flagrantly violated. Staff does not know about the rights of the mentally ill. There is no Board of Visitors. Mental Health Act, 1987 is partially complied with. There are no court representations about this hospital till now. The general living conditions of the inpatients are highly deplorable. They are all infested with scabies and body lice and have ulcers all over their bodies. Lice infestation is so much that all the walls are covered with lice which has made different patterns on the walls. The personal hygiene of the patients is very poor and they do not have structured activity, programs or treatment. Regular ward rounds are not taken. However, patients are seen in the consultation room. There is an inadequacy of staff nurses. There is a large number of ward attenders who are not involved in any of the activity programs, as there are no activity programmes for the patients from morning till evening.



## **Suggestions**

The Medical superintendent feels that there is a need to improve the number of nurses and to improve the living conditions of patients. All the staff shares this sentiment. The public feels that there is a need to provide better ward infrastructure, canteen facilities and recreational activities. The patients feel improvement of diet in terms of quality and quantity is essential. It is very important for this hospital to improve the structure and functioning in toto and there is an urgent need for the training of staff from the Medical Superintendent to the attenders.

It is necessary to provide opportunities for updating the knowledge of medical officers and psychiatrists by encouraging them to attend conferences and CME programs. It is suggested that the government depute the different levels of staff for training to other centres.

This hospital has a potential to be made into a good facility. The large number of attenders and peons need to be reduced as most of them are not functional in the present set up. The same people can be put in charge of regular activity program under supervision of the medical officers. It is necessary to delegate responsibilities to the staff by the medical superintendent.

The most difficult process is to develop a good work culture among the staff. The large open space available can be used for out door activities and rehabilitation work. It is necessary to develop a closed drainage system. Good mental health services need to be provided in this region of the State as no other psychiatric facilities exist.

## **INSTITUTE OF MENTAL CARE, PURULIA**

### **Background**

This is the newest mental hospital in the country. This hospital was established in the year 1994 by the West Bengal government. One of the reasons for its establishment was to take over the States' patients from Ranchi (both CIP and RINPAS). This hospital was not visited as it was discovered only on the visit to West Bengal. The information given here is collated from the proforma that was sent back to the project office. Services started from January 1998 onwards. The original name was Institute for Lunatics.

Governing authority of this hospital is the Government of West Bengal and the first Superintendent is Dr. Subhash Chandra Mullah. The catchment area is the entire Purulia district, part of Dhanpur, Bokaro and Jameshedpur districts. It is very close to the jail. There are only closed wards, which are in the general category. No other types of wards are available. The buildings were apparently that of an old jail and are properly maintained by the Public Works Department.



## **Staff pattern**

There is only one qualified Psychiatrist, 2 General Medical Officers with 36 General Nurses. There are 2 ward masters, 60 attenders and 1 laboratory technician. Posts of clinical psychologists, psychiatric social workers, psychiatric nurses, administrative staff are not there. The majority of the staff members stay on the campus. Working hours of the doctors are from 8 a.m. to 1.00 p.m. and some of the staff members are trained occasionally. There is no regular staff meetings or staff training. To improve the quality of the care, the hospital authorities have suggested creation of the posts of qualified psychiatrists, clinical psychologists, sociologists, physicians and surgeons, occupational therapists and ambulance facilities.

## **Admission and discharge**

No admissions or discharges are done till now in the hospital. Among the existing inpatients, 15 have been transferred from Alipur jail and 65 have been transferred from CIP, Ranchi. As admissions and discharges have not been done, it is not mentioned whether they follow any specific procedure. No arrangements for decertification or discharge has yet been done by the Government of West Bengal. All the patients are long term inmates of Alipur jail or CIP, Ranchi and Government of West Bengal is trying their best to trace the guardians. Patients reportedly have a right for appeal. No donations are received by this hospital.

## **SERVICES**

### **Outpatient services**

Casualty and emergency services are available for the inpatients. They get 5-6 emergency calls once in a week. Routine medical investigations are available for the patients. For specialised services, patients are referred to general hospitals. There is a regular outpatient department. On average, 40 patients attend the OPD per day. Emergency cases are also seen in the outpatient. 10 minutes is the average time allotted for every patient. There is a waiting hall in the OPD for the patients. Free drugs are provided for all the patients in OPD. Free medicines are given only for a week at a time. Rs.1/- is charged for new registration. Toilet facility in the OPD is poor.

### **Inpatient services**

All the patients are provided with food, cot, bed and medical treatment. There is no specific daily activity for patients as all the patients are long term. Daily cleaning and changing of dress is being done, and change of linen is done once in 1-2 days. Each patient has got a cot, mattress and pillow. Specific uniforms are provided for both male and female patients. For every 10 patients, there is one toilet.



Privacy for patients in the ward is reportedly present. There is no recreational facility. There is a facility for keeping the belongings of every individual. The staff maintains a record of menstruation and weight. Shaving of heads of both males and females are done. There is provision for inpatient emergency care. Anti-lice and anti-mosquito measures are done half yearly. 100% of the patients are non-paying. Seclusion wards are available but are not used. Duty rooms are present in the wards. Visiting hours is in the morning and evening. Inpatient facilities are totally adequate. Quality and quantity of the food served is good. The Medical Superintendent checks the quality of the food. The Ward Master is in charge of the food preparation. On average Rs.20/- is charged per day for the diet for patients. Drinking water is provided to the patients through taps inside the wards as well as in mud pots. Food is brought in containers, which are closed. Firewood is used for cooking. Food is served in plates and cups in the verandas. Occasionally, there are complaints regarding the quality of food.

Routine blood and urine investigation facilities are available in the hospital. No other investigation facilities are available. Only drug therapy is available here and no other form of treatment is given. . Service facilities are generally adequate in terms of water, electricity etc. There is no canteen facility available, no telephones and no library. Only one daily newspaper is available for the whole hospital. No rehabilitation or community services are provided.

### **Medical records**

There are separate case files for inpatients. Access of files is only to the treatment team. Rights of the patients are reportedly ensured. The family members, if they come, are allowed but not encouraged to take the patients out. All the patients are allowed to write letters. However, only 30% of the patients write letters. Patients are allowed to talk to recognised social agency personnel. There is no liaison with voluntary agencies.

### **Rights and legal aspects**

It is reported that the staff is aware of the rights of the mentally ill. Apparently, they have been sensitised about this. No Board of Visitors or Management is present and so no meeting has been held till now.

### **Suggestions for the State**

There are six mental health care facilities directly under the Government or run by a receiver. Total bed strength of these hospitals put together is 976. The standards vary among these hospitals and except for one hospital (Pavlov) the others are below standard or very poor. There is a need to appoint a psychiatrist at the level of Additional Director (Mental Health) to oversee all these activities. The following



suggestions may be implemented to improve the plight of the mentally ill as services are inadequate in terms of standards and available beds in this large state.

- Mental Health Act, 1987 must be implemented immediately and in full.
- The Medical Superintendent must be a psychiatrist and head the hospital and be given more autonomy.
- Admission and discharges must follow the Act strictly. There is no need for admissions to be approved by the Directorate of Health Services, as is the practice now.
- Daily Outpatient and Emergency services with interview rooms, waiting hall, medical records, short stay wards and adequate staff must be ensured in all the hospitals.
- Standard psychiatric care in terms of recommended drugs, modified ECT and psychosocial treatments in wards and OPD must be followed in all hospitals.
- Better lab facilities for essential investigations in the OPD and inpatient services.
- Abolish cell admissions in all hospitals immediately.
- Hasten discharge after recovery and minimise hospital days.
- Create open wards and encourage admission to open wards with family member. Avoid closed ward admissions.
- Smaller wards (10-20bed units) with recommended number of staff nurses and ward attenders dedicated to each ward.
- Patients to be seen regularly by a multi-disciplinary team of doctors and other professionals.
- Provision of adequate recommended infrastructure in terms of wards and adjoining facilities. Old structures like jails are not suitable.
- Provision of other amenities like adequate food, medicines, clothing, drinking water, cots, linen, and other necessities.
- Ensure regular water and electricity supply, closed drainage and communications network (telephones and intercom).
- Adequate support services like kitchen, laundry, pharmacy, stores, and maintenance should be present in all hospitals.
- Separate wards for medico-legal patients, medical emergencies, alcohol and drug dependence and children.



- Create recreational facilities attached to every ward.
- Start proper rehabilitation facilities including day care centre.
- Improve staff pattern with recommended psychiatrists, psychiatric nurses, psychiatric social workers, clinical psychologists, occupational therapists, instructors, and ward attenders.
- Start regular in-service training for all staff members.
- Constitute Board of Visitors to act as inspection/monitoring authority for each hospital.
- These hospitals must be made into teaching hospitals with postgraduate students posted in the wards.
- Educate the relatives, public and staff members about mental illness to remove the stigma and for acceptance in the community.
- Encourage close liaison with NGOs as they are quite active and motivated in this State.



# CHAPTER-31

## APPENDICES

### APPENDIX-1

#### 1. BACKGROUND INFORMATION:

- 1.1. Name of the Hospital : \_\_\_\_\_
- 1.2. Address : \_\_\_\_\_  
\_\_\_\_\_
- State: \_\_\_\_\_ Pin code: \_\_\_\_\_
- Telephone # : \_\_\_\_\_
- Fax # : \_\_\_\_\_
- Telex # : \_\_\_\_\_
- Email : \_\_\_\_\_
- 1.3. Year of establishment : \_\_\_\_\_
- 1.4. No. of years of service provision : \_\_\_\_\_
- 1.5. Distance from city centre : \_\_\_\_\_ Kms.
- 1.6. Detailed history of development: \_\_\_\_\_  
of the hospital\* : \_\_\_\_\_  
(Enclose relevant documents, : \_\_\_\_\_  
articles published about the : \_\_\_\_\_  
hospital, photographs) : \_\_\_\_\_  
{Cover the following areas} : \_\_\_\_\_
- a) Origin of the name : \_\_\_\_\_
- b) Earlier names if any : \_\_\_\_\_
- c) Governing authority : \_\_\_\_\_  
- pre 1947 : \_\_\_\_\_  
- post 1947 : \_\_\_\_\_
- d) I Superintendent : \_\_\_\_\_
- e) I Indian Superintendent : \_\_\_\_\_
- f) Significant milestones : \_\_\_\_\_
- g) Catchment area : \_\_\_\_\_
- h) Place of origin : \_\_\_\_\_
- i) Shift of infrastructure : \_\_\_\_\_



- j) MOU with State government : \_\_\_\_\_
- k) MOU with other States : \_\_\_\_\_
- l) Others : \_\_\_\_\_
- (Add additional sheets : \_\_\_\_\_
- if needed and append). : \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



2. HOSPITAL INFRASTRUCTURE:

2.1. Architecture of the hospital :  
(ex.: close proximity to Jail, General Hospital, GHPU) :

2.2.	No.	Types of wards	Available	Total No. of wards existing
2.2.1		Closed wards	Yes \ No	
2.2.2		Open wards	Yes \ No	
2.2.3		Paying wards	Yes \ No	
2.2.4		Family ward	Yes \ No	
2.2.5		Children ward	Yes \ No	
2.2.6		Alcohol & Drug	Yes \ No	
2.2.7		Criminal ward	Yes \ No	
2.2.8		Isolation ward	Yes \ No	
2.2.9		Chronic ward	Yes \ No	
2.2.10		Others, (specify)	Yes \ No	

2.3. In the general category what :  
are the basic facilities :  
available :

2.4. In the paying category what :  
are the extra facilities :  
available :



2.5.	Bed strength:	MALE	FEMALE	CHILDREN	CRIMINAL	TOTAL
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2.6. Describe the administrative set-up of the organisation :  
(Draw the hierarchical chart)

2.7. Are the buildings properly maintained : \_\_\_\_\_

2.8. If not, reasons for the same : \_\_\_\_\_

2.9. Is it a private, or Government building : \_\_\_\_\_

2.10. Persons responsible for maintenance : \_\_\_\_\_

2.11. Describe infrastructural inadequacies if any : \_\_\_\_\_

2.12. If inadequate, suggest remedial measures : \_\_\_\_\_

: \_\_\_\_\_

: \_\_\_\_\_



3. STAFFING PATTERN:

3.1. Staffing pattern (Mention vacancies also)

Designation	# Existing	# Vacancy	Total
Qualified Psychiatrists			
General Medical Officers			
Clinical Psychologists			
Psychiatric\Medical Social Workers			
Trained Psychiatric Nurses			
General Nurses			
Occupational Therapists			
Lab, Radiology Technicians			
Administrative Staff			
Ward Attenders & Peons			
Others, specify			
Others, specify			
Others, specify			

3.2. Non psychiatry visiting consultants: NIL  
1. \_\_\_\_\_ Discipline  
2. \_\_\_\_\_ Discipline  
3. \_\_\_\_\_ Discipline

3.3. Staff members who stay in : \_\_\_\_\_  
in the campus of the : \_\_\_\_\_  
institution : \_\_\_\_\_  
\_\_\_\_\_

3.4. Whether the staff is adequate: \_\_\_\_\_  
\_\_\_\_\_



3.5. Staff pay scales

Designation	Basic	Total Emoluments
Qualified Psychiatrists		
General Medical Officers		
Clinical Psychologists		
Psychiatric\Medical Social Workers		
Trained Psychiatric Nurses		
General Nurses		
Occupational Therapists		
Lab, Radiology Technicians		
Administrative staff		
Ward Attenders & Peons		
Others, specify		
Others, specify		
Others, specify		

3.6. Working hours of the Doctors : \_\_\_\_\_

3.7. Working hours of other staffs: \_\_\_\_\_

3.8. Whether the service condition: \_\_\_\_\_  
is reasonable : \_\_\_\_\_

3.9. Are the staff qualified and : \_\_\_\_\_  
suitable for the job : \_\_\_\_\_

3.10. Are the members of staff : \_\_\_\_\_  
given any special training : \_\_\_\_\_

3.11. Suggest remedial measures for: \_\_\_\_\_  
improving staffing pattern : \_\_\_\_\_



4. ADMISSION AND DISCHARGE:

4.1. Describe the admission and discharge procedures:

4.2. Procedures of admission : 1. Indian Lunacy Act, 1912  
governed by : 2. Mental Health Act, 1987  
: 3. Others, \_\_\_\_\_

4.3. Admitting authorities : 1. Psychiatrist: 2. Hospital Physicians  
: 3. Relatives: 4. Police : 5. Judiciary

4.4. Are the rights of voluntary : 1. Yes  
patients made known to them : 2. No  
at the time of admission

4.5.	Number and type	1992	1993	1994	1995	1996	Total
4.5.1.	Admissions						
	(a) Voluntary						
	(Brought by relatives)						
	(b) Involuntary						
	(Through court)						
4.5.2	Discharges						
4.5.3	Deaths						
4.5.4	Suicide						
4.5.5	Homicide						
4.5.6	Escape						

4.6. Number of patients staying in the hospital:

	1 Yr.	1-2 Yrs	>2-3 Yrs	>5-10 Yrs	>10-15 Yrs	>15 Yrs
MALE						
FEMALE						



- 4.7. Average duration of stay : \_\_\_\_\_ days
- 4.8. Proportion of repeat admissions during last year : \_\_\_\_\_
- 4.9. Reasons for repeat admission :  
 (Rank order your responses)  
 (ex. Patient not fit for discharge.  
 Families not willing to take the patient)
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
  6. \_\_\_\_\_
- 4.10. Decertification done by :  
 1. Board of visitors  
 2. Hospital authorities
- 4.11. Discharge procedures for involuntary admissions :  
 1. Sent with relatives undertaking  
 2. Sent home with hospital escort  
 3. Sent home alone
- 4.12. Problems of discharge :  
 (Prioritize the difficulties)
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
  6. \_\_\_\_\_
- 4.13. Describe the Police Dept. responsibility in discharge? : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 4.14. What are the action strategies to discharge long stay patients : \_\_\_\_\_  
 : \_\_\_\_\_  
 : \_\_\_\_\_  
 \_\_\_\_\_
- 4.15. Any strategy evolved to trace the address of wandering lunatics : \_\_\_\_\_  
 : \_\_\_\_\_  
 : \_\_\_\_\_  
 \_\_\_\_\_
- 4.16. In case of grievances do patients have a right to appeal : 1. Yes      2. No  
 If yes, describe the procedure: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



4.17. Suggest any remedial measures: \_\_\_\_\_  
to improve admission and dis : \_\_\_\_\_  
-charge procedure : \_\_\_\_\_  
\_\_\_\_\_



**5. FINANCE:**

5.1.	Budget	1992	1993	1994	1995	1996	Total
	Plan						
	Non-Plan						
	Special funds for improvement, if any						
5.2.	Mode of expenditure (In % out of total)	1992	1993	1994	1995	1996	Total
	Salaries for staff						
	Drugs						
	Food for patient						
	Linen for patient						
	Equipments						
	Furniture						
	Maintenance						
	Others						
	Total	100%	100%	100%	100%	100%	100%
5.3.	Maintenance of separate accounts for various funds :		1. Yes	2. No.			
5.4.	Donations received in cash :						
	1992						
	1993						
	1994						
	1995						
	1996						
	Total						



5.5. Donations received in kind :  
in the last 5 yrs, describe

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5.6. Is the budgetary allocation : 1. Adequate  
adequate : 2. Inadequate

5.7. If inadequate, suggest :  
remedial measures :



## 6. CASUALTY AND EMERGENCY SERVICES:

- 6.1. Casualty and emergency services : Present \ Absent
- 6.2. Location of the casualty : 1. easily accessible, 2. little difficult  
3. lot of difficulties
- 6.3. Average number of casualties  
per week in the last one year : \_\_\_\_\_
- 6.4. Rank order types of cases: 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_  
6. \_\_\_\_\_
- 6.5. Mode of disposal: 1. Admitted to wards : \_\_\_\_\_ %  
2. Treated on OPD basis : \_\_\_\_\_ %  
3. Referred to other hospital: \_\_\_\_\_ %  
4. Referred for Magistrate's  
order : \_\_\_\_\_ %
- 6.6. Admission to wards from casualty : 1. Admitted immediately  
2. Admission delayed  
3. Not admitted  
4. Not needed
- 6.7. Presence of short stay ward : 1. Present 2. Absent
- 6.8. If present, No. of beds available : \_\_\_\_\_
- 6.9. Ambulance facility : 1. Present 2. Absent
- 6.10. If present, is it available whenever needed? : 1. Yes 2. No
- 6.11. Total number of ambulance : \_\_\_\_\_  
available in the Hospital
- 6.12. Number of roadworthy ambulances : \_\_\_\_\_
- 6.13. List investigation facilities : 1. \_\_\_\_\_ 2. \_\_\_\_\_  
available in the casualty 3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_



- 6.14. Are the minimal required medicines stocked in sufficient quantity      1. Yes  
2. No
- 6.15. Availability of telephone service in casualty      1. Yes      2. No
- 6.16. Availability of casualty staffs : 1. Routinely present, 2. On telephone call  
3. On personal call
- 6.17. If specialists services are needed : \_\_\_\_\_  
what arrangements are available : \_\_\_\_\_  
\_\_\_\_\_
- 6.18. Quality of the equipments in casualty      1. Good,      2. Average      3. Poor
- 6.19. Are the facilities in casualty adequate : 1. Adequate      2. Inadequate
- 6.20. If inadequate, suggest remedial : \_\_\_\_\_  
measures : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **7. OUTPATIENT SERVICES:**

7.1. Out - patient Services : Present / Absent.

7.2. If present, frequency : Daily / Weekly / Twice/ Thrice / Weekly Once.

7.3. Out patient service timings. : \_\_\_\_\_

7.4. No. of cases seen in OPD/per day : \_\_\_\_\_

7.5. No. of emergency cases seen  
in OPD/per day : \_\_\_\_\_

7.6. No. of patients brought chained \ roped : \_\_\_\_\_

7.7. Number of staff posted to  
OPD in the last 5 Years :

Designation	1992	1993	1994	1995	1996
Trained Psychiatrists	_____	_____	_____	_____	_____
General Medical Officers	_____	_____	_____	_____	_____
Clinical Psychologists	_____	_____	_____	_____	_____
Psychiatric Social Workers	_____	_____	_____	_____	_____
Trained Psychiatric Nurses	_____	_____	_____	_____	_____
General Nurses	_____	_____	_____	_____	_____
Technicians	_____	_____	_____	_____	_____
Administrative Staff	_____	_____	_____	_____	_____
Attenders & peons	_____	_____	_____	_____	_____
Others, specify _____	_____	_____	_____	_____	_____
Others, specify _____	_____	_____	_____	_____	_____

7.8. Total No. of interview rooms  
in the OPD : \_\_\_\_\_

7.9. Average time spent on each patient : \_\_\_\_\_

7.10. Average time allotted to each  
patient on his subsequent visit : \_\_\_\_\_

7.11. Average waiting time for a patient  
to be seen by a doctor? : \_\_\_\_\_



- 7.12. Waiting hall for the patient in the OPD: 1. Present 2. Absent
- 7.13. Average No. of persons who could be accommodated in waiting hall : \_\_\_\_\_ %
- 7.14. Waiting room - seating arrangements: 1. Present 2. Absent
- 7.15. Waiting room - seating conditions : 1. Good 2. Average 3. Poor  
4. Not present
- 7.16. Availability of Free Drugs : (a) To all patients (b) To > 15% patients  
in the OPD (c) To 50 - 75% “ (d) To 25 - 50% “  
(e) To <25% patients (f) To None
- 7.17. % of deserving patients getting the benefit of free drugs? : \_\_\_\_\_ %
- 7.18. List of free drugs provided : 1. \_\_\_\_\_  
(attach separate sheet if needed) 2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_  
6. \_\_\_\_\_
- 7.19. Duration of free drug provision : \_\_\_\_\_
- 7.20. Registration fee, if any : Rs. \_\_\_\_\_
- 7.21. Charges for other OP services : \_\_\_\_\_  
(attach fee chart if available)  
\_\_\_\_\_
- 7.22. Are the facilities in out patient : 1. Adequate  
adequate 2. Inadequate
- 7.23. If inadequate, suggest remedial : \_\_\_\_\_  
measures : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**8. INPATIENT SERVICES:**

- 8.1. Description of a typical days activities for the patients
- 
- 8.2. Cleaning of the in-patient wards : 1. Daily 2. Once in 2-3 days  
3. Once a week 4. Once a fortnight  
5. Once a month
- 8.3. Frequency of bath for in-patients : 1. Daily 2. Once in 2-3 days 3. Once a week  
4. Once a fortnight 5. Once a month
- 8.4. Frequency of dress change : 1. Daily 2. Once in 2-3 days  
3. Once a week 4. Once a fortnight  
5. Once a month
- 8.5. Frequency of linen change : 1. Daily 2. Once in 2-3 days  
3. Once a week 4. Once a fortnight  
5. Once a month
- 8.6. Plinth area per patient :
- 8.7. Availability of

In wards

In stock

Cots

Mattresses

Linen

Pillows

Warm clothes

Blankets

# of pillows / patient

# of blankets / patient

# of sweaters / patient

# of towels / patient
- 8.8. Are patients allowed to wear their own dress: 1. Yes 2. No
- 8.9. If no, any specific reasons :
- 8.10. Specific uniforms for males : 1. Present 2. Absent
- 8.11. Type and colour of the uniform :



- 8.12. Specific uniforms for females : 1. Present 2. Absent
- 8.13. Type and colour of the uniform : \_\_\_\_\_
- 8.14. No. of uniform available \ patient : \_\_\_\_\_
- 8.15. No. of washing platforms Male ward : \_\_\_\_\_
- 8.16. Basic facilities in the wards like  
Ratio of Toilet/patient : \_\_\_\_\_  
Ratio of Fans/ patient : \_\_\_\_\_  
Ratio of Cots-Beds/patient : \_\_\_\_\_  
Ratio of Chairs/patient : \_\_\_\_\_
- 8.17. Privacy for the patient in wards : 1. Present 2. Absent
- 8.18. Provision of recreational facilities in the ward : 1. Yes 2. No
- 8.19. If yes, provisions available : \_\_\_\_\_  
(ex. carom board) : \_\_\_\_\_  
\_\_\_\_\_
- 8.20. Facilities for keeping patient belongings in the ward : 1. Present 2. Absent
- 8.21. If present, : 1. For every individual 2. Common for all  
3. On sharing basis
- 8.22. Do the staff maintain record of menstruation : 1. Yes 2. No
- 8.23. Do the staff maintain record of each patient's weight : 1. Yes 2. No
- 8.24. Shaving of head for patients :  
Male :1. Yes 2. No  
Frequency : \_\_\_\_\_  
Female :1. Yes 2. No  
Frequency : \_\_\_\_\_
- 8.25. Hair cut and face shaving for male patients : 1. Yes 2. No  
If yes, frequency of hair cut : \_\_\_\_\_  
If yes, frequency of face shave : \_\_\_\_\_



- 8.26. Provision of in-patient emergency care: 1. Present 2. Absent
- 8.27. Anti lice / bug measures adopted : 1. Present 2. Absent
- 8.28. If present, frequency : 1. Quarterly 2. Half yearly 3. Annually
- 8.29. Anti mosquito measures : 1. Present 2. Absent
- 8.30. If present, type : 1. Window attached mosquito mesh  
2. Cot mounted net  
3. Chemical repellents
- 8.31. Percentage of paying patients : \_\_\_\_\_ %
- 8.32. Percentage of non-paying patients: \_\_\_\_\_ %
- 8.33. Criteria for free patient declarations : \_\_\_\_\_  
\_\_\_\_\_
- 8.34. Seclusion wards / single rooms : 1. Present 2. Absent  
with iron gates.
- 8.35. If yes, number of rooms : \_\_\_\_\_
- 8.36. Usage of such rooms : 1. Regularly 2. Occasionally 3. Not at all
- 8.37. Presence of duty room in wards : 1. Yes 2. No
- 8.38. If present, facilities provided  
in the duty room : \_\_\_\_\_  
(ex. examination table, \_\_\_\_\_  
chairs for the patient) \_\_\_\_\_
- 8.39. Visiting hours : Morning \_\_\_\_\_ Afternoon \_\_\_\_\_  
Evening \_\_\_\_\_ Any time \_\_\_\_\_
- 8.40. Are the facilities in inpatient : 1. Adequate  
adequate 2. Inadequate
- 8.41. If inadequate, suggest remedial : \_\_\_\_\_  
measures : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**9. DIETARY AND PANTRY FACILITY:**

- 9.1. What is the prescription regarding : \_\_\_\_\_  
quantity and quality of food : \_\_\_\_\_  
\_\_\_\_\_
- 9.2. What is budgetary allocation for : 1992 Rs. \_\_\_\_\_  
food for the past 5 years : 1993 Rs. \_\_\_\_\_  
: 1994 Rs. \_\_\_\_\_  
: 1995 Rs. \_\_\_\_\_  
: 1996 Rs. \_\_\_\_\_
- 9.3. Who is in charge of preparation : \_\_\_\_\_  
of food : \_\_\_\_\_
- 9.4. Who checks the quality and : \_\_\_\_\_  
quantity of food served : \_\_\_\_\_
- 9.5. Free diet facility provision : 1. For all in-patients 2. Selected in-patients  
3. For none
- 9.6. Cost of diet rate/patient : \_\_\_\_\_
- 9.7. Percentage of patient provided  
with special diet : \_\_\_\_\_
- 9.8. Cost of special diet rate/ patient : \_\_\_\_\_
- 9.9. Supply of seasonal fruits : 1. Yes 2. No
- 9.10. Calorie supply / patient  
Breakfast : \_\_\_\_\_  
Lunch : \_\_\_\_\_  
Dinner : \_\_\_\_\_
- 9.11. Supply of coffee\tea\milk : 1. Yes 2. No
- 9.12. Service timings of diet : Breakfast : \_\_\_\_\_  
Lunch : \_\_\_\_\_  
Dinner : \_\_\_\_\_
- 9.13. Provision of drinking water : 1. Taps inside the ward  
to patients 2. Stainless steal container 3. Mud pot with dipper  
4. Personal arrangement



- 9.14. Provision of water cooler : 1. Yes                      2. No
- 9.15. No. of water coolers present : \_\_\_\_\_
- 9.16. Food supply : 1. Containers carried by patients  
2. Hand pulled trolley                      3. Electrical trolley  
4. Closed container trolley
- 9.17. Food supply provision : 1. Closed container 2. Open vessels
- 9.18. No. of open containers & capacity : \_\_\_\_\_
- 9.19. No. of closed containers & capacity: \_\_\_\_\_
- 9.20. Details of diet and diet schedule : \_\_\_\_\_  
(attach separate sheet) \_\_\_\_\_
- 9.21. Mode of cooking : 1. Fire wood                      2. Gas                      3. Steam supply
- 9.22. Hygienic condition of the pantry : 1. Very good 2. Good                      3. Average 4. Poor
- 9.23. Mode of serving : 1. Plates & cups                      2. Plantain leaf
- 9.24. Serving of diet : 1. At dining hall                      2. Verandah: 3. On the bed  
4. Open space
- 9.25. Complaints on quantity and quality : 1. Everyday  
of food supplied to patients                      2. Once a week                      3. Once a month  
4. Occasionally                      5. Never
- 9.26. Reasons for complaints on quality : \_\_\_\_\_  
and quantity of food supplied : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 9.27. Suggest remedial measures to : \_\_\_\_\_  
improve dietary and pantry : \_\_\_\_\_  
measures : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**10. INVESTIGATION AND TREATMENT FACILITIES:**

10.1. Investigatory facilities (Medical):

	INPATIENT		OUTPATIENT	
(a) Routine Blood/Urine:	Yes	No	Yes	No
(b) Special Blood/CSF :	Yes	No	Yes	No
(c) Blood sugar :	Yes	No	Yes	No
(d) VDRL :	Yes	No	Yes	No
(e) Lithium estimation :	Yes	No	Yes	No
(f) X-rays :	Yes	No	Yes	No
(g) EEG :	Yes	No	Yes	No
(h) HIV screening :	Yes	No	Yes	No
(i) Hepatitis B :	Yes	No	Yes	No

10.2. Investigatory facilities(Psycho-social):

(a) IQ \ Cognitive functions :	Yes	No	Yes	No
(b) Personality assessment :	Yes	No	Yes	No
(c) Diagnostic psychological test :	Yes	No	Yes	No
(d) Home visits :	Yes	No	Yes	No
(e) Collateral contacts :	Yes	No	Yes	No

10.3. Charges for investigations

(1) Routine Blood/Urine :	Rs._____	Rs._____
(2) Special Blood/CSF :	Rs._____	Rs._____
(3) Blood sugar :	Rs._____	Rs._____
(4) VDRL :	Rs._____	Rs._____
(5) Lithium estimation :	Rs._____	Rs._____
(6) X-rays :	Rs._____	Rs._____
(7) EEG :	Rs._____	Rs._____
(8) HIV screening :	Rs._____	Rs._____
(9) Hepatitis B :	Rs._____	Rs._____



10.4. Charges for assessments

(1) IQ\Cognitive functions :	Rs. _____	Rs. _____
(2) Personality assessment :	Rs. _____	Rs. _____
(3) Diagnostic psychological test :	Rs. _____	Rs. _____
(4) Home visits :	Rs. _____	Rs. _____
(5) Collateral contacts :	Rs. _____	Rs. _____

10.5. Timings for various investigations:

	INPATIENT	OUTPATIENT

10.6. Timings for issue of the results :  
of investigation

	INPATIENT	OUTPATIENT

10.7. Treatment facilities (Medical)

	INPATIENT	OUTPATIENT
(a) Pharmacotherapy :	Yes No	Yes No
(b) Direct ECT :	Yes No	Yes No
(c) Modified ECT :	Yes No	Yes No

10.8. Treatment facilities(Psycho-social)

(a) Psychotherapy\counselling :	Yes No	Yes No
(b) Behaviour Therapy :	Yes No	Yes No
(c) Psycho-education :	Yes No	Yes No
(d) Rehabilitation :	Yes No	Yes No

10.9. Control of violent patient's :

(a) Physical restraint	(b) Pharmacotherapy
(c) Seclusion ward	(d) Combination
(e) Others: _____	



10.10. Specific problems in investigatory: \_\_\_\_\_  
and treatment facilities : \_\_\_\_\_  
\_\_\_\_\_

10.11. Suggest remedial measures to : \_\_\_\_\_  
improve investigatory and : \_\_\_\_\_  
treatment facilities : \_\_\_\_\_



## **11. MEDICAL RECORDS:**

- 11.1. Are there separate case file for : 1. Yes 2. No  
each patient
- 11.2. If no, reasons for the same : \_\_\_\_\_  
\_\_\_\_\_
- 11.3. Average time taken to retrieve :  
case files  
\_\_\_\_\_
- 11.4. Total number of case files :  
maintained \_\_\_\_\_
- 11.5. Total No. of staff in :  
Medical Records Department \_\_\_\_\_
- 11.6. Maintenance of case files : 1. Papers clipped 2. Individual files  
3. Box files for a group of patients
- 11.7. Filing of unit wise results of : 1. Separately  
investigations, particulars of 2. Individual pt. file  
patients, correspondence etc., 3. Category wise
- 11.8. Retrieval of files from medical : 1. Whenever needed  
records. 2. On request only
- 11.9. Percentage of patient's file  
non retrievable : \_\_\_\_\_%
- 11.10. Access of patient records : 1. To all 2. To treatment team  
3. On request by agency
- 11.11. Confidentiality of case records : 1. Confidential 2. Not confidential
- 11.12. Complaints on record maintenance: 1. Yes 2. No
- 11.13. If yes, please describe the specific complaints : \_\_\_\_\_  
\_\_\_\_\_
- 11.14 Suggest remedial measures to : \_\_\_\_\_  
improve medical record keeping : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**12. RIGHTS OF PATIENTS:**

- 12.1. Explanation on the nature of illness, treatment, prognosis of the patient given to family : 1. Not provided  
2. Provided to few  
3. Provided to all
- 12.2. Are family members allowed to see the patients in wards. : 1. Not allowed  
2. Few are allowed 3. All are allowed
- 12.3. Are they encouraged to take the patient out and take part in recreation activities? : 1. Not encouraged  
2. Few are encouraged  
3. All are encouraged
- 12.4. Describe any programme for family intervention? : \_\_\_\_\_  
: \_\_\_\_\_  
\_\_\_\_\_
- 12.5. Do the patients write letters to their home : 1. Not allowed  
2. Few are allowed 3. All are allowed
- 12.6. If yes, % of patients who do write letters to their home? : \_\_\_\_\_
- 12.7. Are the patients allowed to talk to recognised/authorised social agency personnel : 1. Not allowed  
2. Allowed  
3. Against the hospital norms
- 12.8. Is there any liaison/collaboration with NSS\Schools\College\Agency : 1. Yes 2. No  
3. Specific restrictions
- 12.9. What is the frequency of visit of collaborative organisations : \_\_\_\_\_
- 12.10. What is the average period of leave of absence : \_\_\_\_\_
- 12.11. Describe the care for the discharged patients : \_\_\_\_\_  
\_\_\_\_\_
- 12.12. Are the staff aware of the rights of mentally ill? : 1. All are aware  
2. Few are aware 3. None are aware 4. Not known
- 12.13. Have they been sensitized about the same? : 1. Yes 2. No
- 12.14. Suggest measures to sensitize the staff about the rights of the mentally ill: \_\_\_\_\_  
\_\_\_\_\_



### 13. SERVICES & FACILITIES:

- 13.1. Electricity facility in the: 1. Adequate  
hospital 2. Inadequate
- 13.2. Presence of generator facility : 1. Present  
in case of electricity failure 2. Absent
- 13.3. Drainage facility of the hospital : 1. Open type 2. Closed type  
3. Open & closed
- 13.4. Water facility in the campus : 1. Adequate 2. Inadequate
- 13.5. Current water storage capacity : \_\_\_\_\_ C.Lts.
- 13.6. Availability of canteen facilities : 1. Adequate 2. Inadequate
- 13.7. Telephone facility in the hospital: 1. Adequate 2. Inadequate
- 13.8. Library facility for patients : 1. Present 2. Absent
- 13.9. If present, detail # available : Daily newspapers : \_\_\_\_\_  
Magazines : \_\_\_\_\_  
Storybooks : \_\_\_\_\_  
Textbooks : \_\_\_\_\_
- 13.10 Library facility for staff and Trainees : 1. Present 2. Absent
- 13.11. If present, detail # available : Textbooks : \_\_\_\_\_  
Journals : \_\_\_\_\_  
Periodicals : \_\_\_\_\_  
Reports : \_\_\_\_\_
- 13.12. Recreational, social and religious facilities available for patients
- |                 |            |           |
|-----------------|------------|-----------|
| Volleyball :    | 1. Present | 2. Absent |
| Badminton :     | 1. Present | 2. Absent |
| Carom :         | 1. Present | 2. Absent |
| Singing :       | 1. Present | 2. Absent |
| Prayer hall :   | 1. Present | 2. Absent |
| Temple :        | 1. Present | 2. Absent |
| Bhajan :        | 1. Present | 2. Absent |
| Tape recorder : | 1. Present | 2. Absent |
| Television :    | 1. Present | 2. Absent |
| Others :        | 1. Present | 2. Absent |



## **14. BOARD OF VISITORS \ MANAGEMENT:**

- 14.1. Describe the decertification : \_\_\_\_\_  
procedure adopted in your \_\_\_\_\_  
institution \_\_\_\_\_  
\_\_\_\_\_
- 14.2. Presence of Board of Visitors or  
Board of Management : 1. Yes 2. No
- 14.3. If present, detail the composition  
of the Board : \_\_\_\_\_  
\_\_\_\_\_
- 14.4. Byelaws regarding procedures to : \_\_\_\_\_  
be adopted in the Board or other \_\_\_\_\_  
Sub-committees. \_\_\_\_\_
- 14.5. Frequency of the Board of visitors \  
Management meeting : \_\_\_\_\_
- 14.6. Percentage of all admissions with  
involvement of legal procedures : \_\_\_\_\_
- 14.7. Percentage of all readmission  
involving legal procedures : \_\_\_\_\_
- 14.8. Implementation of Mental Health : 1. Fully complied 2. Partially complied  
Act of 1987 3. Not complied
- 14.9. Reasons for partial or : \_\_\_\_\_  
non-compliance \_\_\_\_\_  
\_\_\_\_\_
- 14.10. Detail the problems in : \_\_\_\_\_  
implementing the MH Act of 1987 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 14.11. Suggest remedial measures towards: \_\_\_\_\_  
implementation of MH Act : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **15. REHABILITATION SERVICES:**

- 15.1. Presence of separate section for Rehabilitation and vocational training in the Mental Hospital : 1. Present 2. Absent
- 15.2. If present, enumerate vocational : \_\_\_\_\_  
sections \_\_\_\_\_  
\_\_\_\_\_
- 15.3. Presence of sheltered workshop : 1. Present 2. Absent
- 15.4. If present, enumerate sheltered : \_\_\_\_\_  
workshop \_\_\_\_\_  
\_\_\_\_\_
- 15.5. Presence of Occupational therapy : 1. Present 2. Absent
- 15.6. If present, enumerate Occupational: \_\_\_\_\_  
therapy programme \_\_\_\_\_  
\_\_\_\_\_
- 15.7. Presence of scheduled activity : 1. For all  
programmes 2. Selected few
- 15.8. Presence of day care facility  
(ex. patient's coming from home  
to the rehabilitation centre) : 1. Present 2. Absent
- 15.9. Is there a regular production : 1. Present 2. Absent
- 15.10 If present, describe the products : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 15.11 Rehabilitation ward in the hospital: 1. Present 2. Absent
- 15.12 If present, number of wards : \_\_\_\_\_  
Number of inmates : \_\_\_\_\_  
Facilities provided : \_\_\_\_\_



15.13 Describe the half way home facilities in the area : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15.14 Presence of long stay facilities : 1. Present 2. Absent

15.15 If present, number of wards : \_\_\_\_\_  
Number of inmates : \_\_\_\_\_  
Facilities provided : \_\_\_\_\_

15.16 Rehabilitation programmes : 1. Combined for males & females  
2. Only for males 3. Only for females  
4. Separate for both genders

15.17 Rehabilitation facilities for the mentally ill children : 1. Combined with adults 2. Separate for children  
3. Not present

15.18 Rehabilitation programme for mentally ill and mentally retarded: 1. Separate 2. Combined

15.19 Categories and # of patients attending the Rehabilitation Centre

Psychosis : \_\_\_\_\_  
Mental retardation : \_\_\_\_\_  
Neurosis : \_\_\_\_\_  
Epilepsy : \_\_\_\_\_  
Alcohol and drug abuse : \_\_\_\_\_

15.20 Total intake capacity of the : \_\_\_\_\_  
Rehabilitation Centre : \_\_\_\_\_

15.21 Number of beneficiaries currently : \_\_\_\_\_  
availing the facilities : \_\_\_\_\_

15.22 Average placement per month in vocations  
Outside the hospital : \_\_\_\_\_  
Inside the hospital : \_\_\_\_\_

15.23 Facility for sales of the products: 1. Present 2. Absent

15.24 Are the patients used for routine : 1. Yes 2. No  
hospital work



- 15.25 Are the patients paid incentives : 1. Yes 2. No
- 15.26 If so, describe the procedure : \_\_\_\_\_  
adopted \_\_\_\_\_  
\_\_\_\_\_
- 15.27 Therapeutic techniques followed  
in rehabilitation : 1. Behavioural modification 2. Therapeutic community  
3. Transactional analysis 4. Eclectic approach  
5. Individual counselling 6. Family counselling  
7. Group approaches
- 15.28 Is there a programme for pre and post assessment of the patient  
in the rehabilitation centre : 1. Present 2. Absent
- 15.29 If present, describe the procedure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 15.30 Facilities for volunteers participation and programmes in the rehabilitation activities  
1. Present 2. Absent
- 15.31 If present, describe the programmes : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 15.32 Type of volunteers : 1. House-wives 2. Voluntary agency personnel  
3. College student volunteers 4. Family members  
5. Others, specify :
- 15.33 Describe the families role in \_\_\_\_\_  
rehabilitation programme \_\_\_\_\_  
(Planing, training and placement) \_\_\_\_\_
- 15.34 Facilities for NGOs participation and programmes in the rehabilitation activities :  
1. Present 2. Absent
- 15.35 If present, describe the programmes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 15.36 Type and number of NGOs involved : 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_



15.37 Describe any disability benefits : \_\_\_\_\_  
provided by the hospital : \_\_\_\_\_

15.38 Describe any conveyance assistance: \_\_\_\_\_  
subsidy provided by the State for : \_\_\_\_\_  
the mentally ill : \_\_\_\_\_

15.39 Staffing pattern of the Rehabilitation Centre (Mention vacancies also)

Designation	# Existing	# Vacancy	Total
-------------	------------	-----------	-------

- 1. Occupational Therapist
- 2. Psychiatric Nurse for Rehabilitation
- 3. Psychologists
- 4. Social Workers
- 5. Vocational Instructors
- 6. Rehabilitation Assistants
- 7. Others, specify \_\_\_\_\_  
(e.g. Dance teacher, Music teacher etc.,)

15.40 Do you have any difficulty in the area of rehabilitation : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15.41 Describe any specific inputs needed in the area of rehabilitation services ? : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## 16. COMMUNITY SERVICES:

- 16.1. Describe the existing community : \_\_\_\_\_  
mental health activities and : \_\_\_\_\_  
services carried out by : \_\_\_\_\_  
the Hospital? : \_\_\_\_\_  
(Append extra sheet if needed) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 16.2. Describe activities undertaken : \_\_\_\_\_  
towards implementation of National: \_\_\_\_\_  
Mental Health Programme for India : \_\_\_\_\_  
\_\_\_\_\_
- 16.3. Presence of trained trainers in : \_\_\_\_\_  
extension of mental health \_\_\_\_\_  
services (Total # and Name) \_\_\_\_\_
- 16.4. Problems reported in extension of : \_\_\_\_\_  
mental health services to rural \_\_\_\_\_  
areas : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 16.5. Are there any training/teaching : 1. Present  
activities for non-mental health : 2. Absent  
professionals
- 16.6. If present, describe : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 16.7. Report on the ongoing District : \_\_\_\_\_  
Mental Health programme in the \_\_\_\_\_  
State and the involvement of \_\_\_\_\_  
the institution \_\_\_\_\_  
\_\_\_\_\_
- 16.8. Any other community out-reach : \_\_\_\_\_  
programmes carried out by the \_\_\_\_\_  
institution \_\_\_\_\_  
\_\_\_\_\_



16.9. Are there any extension service : \_\_\_\_\_  
programme outside the Medical : \_\_\_\_\_  
Hospital like consultations, visit: \_\_\_\_\_  
to Jails/Remand Homes/Destitute : \_\_\_\_\_  
Homes etc? If yes, details. : \_\_\_\_\_  
\_\_\_\_\_

16.10. Provision of MH care at General : 1. Present 2. Absent  
Hospital Psychiatric Units and  
District Hospitals

16.11. If present, number of GHPUs : \_\_\_\_\_  
Number of DHPUs : \_\_\_\_\_

16.12. What are the stumbling blocks in : \_\_\_\_\_  
extension of mental health care : \_\_\_\_\_  
activities : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16.13. Suggest remedial measures towards : \_\_\_\_\_  
organisation of community mental : \_\_\_\_\_  
health activities : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## 17. STAFF TRAINING:

17.1. Do meetings of the following staff take place ?

- |                          |   |        |       |
|--------------------------|---|--------|-------|
| (a) Medical Staff        | : | 1. Yes | 2. No |
| (b) Non-Medical MH staff | : | 1. Yes | 2. No |
| (c) Nurses               | : | 1. Yes | 2. No |
| (d) Ward-attenders       | : | 1. Yes | 2. No |
| (e) Class -D             | : | 1. Yes | 2. No |

17.2 If so, how frequently : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17.3. Are there any in service training : 1. Present  
programme for the Medical and 2. Absent  
Non-Medical Staff?

17.4. If so, describe : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17.5. Percentage of staff burn out among the total staff : \_\_\_\_\_ %

17.6. What are the main reasons for : \_\_\_\_\_  
amotivation among the staff for : \_\_\_\_\_  
mental health care activities : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17.7. Suggest remedial measures towards : \_\_\_\_\_  
increasing motivation among staff : \_\_\_\_\_  
for mental health care activities : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **18. COURT REPRESENTATIONS AND ORDERS:**

- 18.1. Is there any patient ill treatment : \_\_\_\_\_  
complaints lodged in the court ? : \_\_\_\_\_
- 18.2. If so, # of cases represented? : \_\_\_\_\_
- 18.3. Any public interest litigation : \_\_\_\_\_  
against the hospital? : \_\_\_\_\_  
\_\_\_\_\_
- 18.4. If so, details. : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 18.5. Directions given by any court : \_\_\_\_\_  
regarding the functioning of your : \_\_\_\_\_  
institution : \_\_\_\_\_  
\_\_\_\_\_
- 18.6. Compliance to directions of the : \_\_\_\_\_  
Supreme Court Order : \_\_\_\_\_  
\_\_\_\_\_
- 18.7. Describe the problem's with : \_\_\_\_\_  
Magistrate cases in admission : \_\_\_\_\_  
and discharge : \_\_\_\_\_  
\_\_\_\_\_
- 18.8. What are the specific reasons for : \_\_\_\_\_  
court interventions and directions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 18.9. Suggest remedial measures towards : \_\_\_\_\_  
prevention of court interventions : \_\_\_\_\_  
and directions : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



### 19. ADEQUACY OF CARE:

### 19.1 Adequacy of care

### - Professional's view

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

## 19.2 Adequacy of care

- Public view

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.



## 20. QUALITY OF CARE FOR THE MENTALLY ILL

20. Please detail any scope for improvement in the quality of care for the mentally ill.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

**THANK YOU FOR YOUR CO-OPERATION**



## CERTIFICATE

Certified that the particulars in respect of \_\_\_\_\_

---

(herein mention the Name of the Institution) given under S. Nos. 1 to 20 of the above questionnaire are true to the best of my knowledge and belief.

Dated: \_\_\_\_\_

Signature: \_\_\_\_\_

Designation: \_\_\_\_\_

Seal of the Institution.



## LIST OF GOVERNMENT MENTAL HOSPITALS IN INDIA

### ANDHRA PRADESH

1. Institute of Mental Health  
Govt. Hospital for Mental Care,  
S.R.Nagar, Hyderabad.  
Pin code: 500038  
Tel: 3814441, 3814442, 3815232, 3814270.  
Fax: 3814270.
2. Government Hospital for Mental Care  
Chinnawaltair, Vishakapatnam,  
Andhra Pradesh.  
Pin code: 500 023  
Tel: 554 918      Res. 551286

### ASSAM

3. Lokopriya Gopinath Bordoloi Institute of Mental Health  
P.O. Tezpur, Dist. Sonitpur  
Assam  
Pin code: 784 001  
Tel: 20114

### BIHAR

4. Central Institute of Psychiatry  
Kanke P.O., Ranchi  
Bihar  
Pin code: 834 006  
Tel: 455 109, 455618  
Fax: 455111



5. Ranchi Institute of Neuropsychiatry and Allied Sciences ( RINPAS)  
Kanke, Ranchi  
Bihar  
Pin code: 834006  
Tel: 226147

## **DELHI**

6. Institute of Human Behavior & Allied Sciences  
G.T. Road, P.O. Box 9520, Jhilmil,  
Delhi  
Pin code: 110 095  
Tel: 2283056, 2283355, 2283062  
Fax: 2299227

## **GOA**

7. Institute of Psychiatry & Human Behavior  
Altinho, Panaji,  
Goa.  
Pin code: 403 001  
Tel: 226147 / 220198

## **GUJARAT**

8. Hospital for Mental Health,  
Bhuj,  
Gujarat.  
Pin code: 370001  
Tel: 02832-25054
9. Hospital for Mental Health,  
Vikasgruh Road,  
Jamnagar,  
Gujarat  
Pin code: 361008  
Tel: 78318



10. Hospital for Mental Health,  
Behind Kapadia High School, Outside Delhi Gate,  
Shahibaug Road,  
Ahamedabad 380 004.  
Gujarat  
Pin code: 380004  
Tel: 079-5622485, 5624583
11. Hospital for Mental Health  
Karelibag,  
Baroda,  
Gujarat.

### **JAMMU AND KASHMIR**

12. Psychiatric Diseases hospital GMC, Jammu  
Ambphalla B.C. Road,  
Jammu  
Pin code: 180001  
Tel: 0191 – 577444

### **KARNATAKA**

13. Karnataka Institute of Mental Health  
Belgaum Road, Dharwad  
Karnataka  
Pin code: 580 008  
Tel: 748 400.
14. National Institute of Mental Health and Neuro Sciences  
NIMHANS, P.O. Box No 2900, Bangalore,  
Karnataka  
Pin code: 560 029  
Tel: 080 – 6642121  
Fax: 080 – 6631830



## KERALA

15. Mental Health Centre  
Oolampara, Thiruvananthapuram  
Kerala  
Pin code: 695 005  
Tel: 432 689
16. Govt. Mental Health Centre,  
Kuthiravattom P.O., Kozhikode  
Kerala  
Pin code: 673 016  
Tel: 355386
17. Govt. Mental Health Centre  
Poothole P.O., Thrissur,  
Kerala  
Pin code: 680 004  
Tel: 423 481

## MADHYA PRADESH

18. Gwalior Manasik Arogyasala,  
Central Jail Road, Gwalior,  
Madhya Pradesh  
Pin code: 4740 012  
Tel: 421 541, 330 359
19. Mental Hospital  
Banganga Saver Road, Indore  
Madhya Pradesh  
Pin code: 452 002  
Tel: 421 545, 421 710

## MAHARASHTRA

20. Regional Mental Hospital  
Nagpur, Maharashtra  
Pin code: 440029  
Tel: 583199, 583176, 583150



21. Regional Mental Hospital  
Yeravda, Pune  
Maharashtra  
Pin code: 411006  
Tel: 0212- 662543, 661275, 666890.

22. Regional Mental Hospital  
Ratnagiri,  
Maharashtra  
Pin code: 415612  
Tel: 22345,22453

23. Regional Mental Hospital  
Wagle Estate,  
Postbox No. 411, Thane (W)  
Maharashtra  
Pin code: 400604  
Tel: 5321810

#### **NAGALAND**

24. Mental Hospital  
Post Box: 433, Kohima  
Nagaland  
Pin code: 797001

#### **ORISSA**

25. Mental Health Institute  
S.C.B. Medical College,  
Cuttack, Orissa  
Pin code: 753 007  
Tel: 614359

#### **PUNJAB**

26. Dr. Vidyasagar Punjab Mental Hospital,  
Circular Road, Amritsar,  
Punjab.  
Pin code: 143001,  
Tel: 222920.



## **RAJASTHAN**

27. Medical College / Psychiatric Centre  
Janta Colony, Jaipur,  
Rajasthan.  
Pin code: 302004  
Tel: 663737, 607967

## **TAMIL NADU**

28. Institute of Mental Health  
Medavakkam Tank Road  
Kilpauk, Chennai  
Tamil Nadu  
Pin code: 600010  
Tel: 6421085

## **UTTAR PRADESH**

29. Agra Manasik Arogyashala  
Billochpura  
Mathura Road, Agra  
Uttar Pradesh  
Pin code: 282002  
Tel: 321011, 322650  
Fax: 321 011
30. Mental Hospital Bareilly  
Civil Lines, Bareilly  
Uttar Pradesh  
Pin code: 243005  
Tel: 457046
31. Mental Hospital  
S2/1 Pandeypur  
Varanasi  
Uttar Pradesh  
Pin code: 221002  
Tel: 348278



## WEST BENGAL

32. Lumbini Park Mental Hospital  
115, G. S. Bose Road,  
Calcutta,  
West Bengal.  
Pin code: 700 010  
Tel: 3434384
33. Calcutta Pavlov Hospital  
18, Gobra Road,  
Calcutta,  
West Bengal  
Pin code: 700 046  
Tel: 329-7170
34. Institute of Psychiatry  
7, D.L. Khan Road,  
Calcutta,  
West Bengal.  
Pin code: 700025  
Tel: 223 2841 / 223 – 6048
35. The Mental Hospital ( Calcutta & Mankundu)  
133, Vivekananda Road,  
Calcutta  
West Bengal  
Pin code: 700006
36. Institute for Mental Care,  
Purulia P.O.,  
Purulia,  
West Bengal  
Pin code: 723103
37. Mental Hospital Berhampore,  
Berhampore Mental Hospital, Berhampore P.O.,  
Murshidabad  
West Bengal  
Pin code: 74 2101  
Tel: 03482 – 52508



**List Of General Hospital Psychiatry Units/ Medical College Psychiatry  
Departments  
Assessed During the Project**

**ASSAM**

Guwahati Medical College Hospital.  
Bhangagarh, Guwahati.  
Assam  
Pin code: 781 032.  
Tel: 0361-56132

**BIHAR**

Patliputra Medical College/Hospital.  
Saraidhela,  
Dhanbad, Bihar.  
Pin code: 826 005.  
Tel: 204165.

**GUJARAT**

Medical College, Baroda & S.S.Q Hospital  
Jail Road, Baroda  
Gujarat  
Pin code: 390 001.  
Tel: 421594, 427545

Shri. M.P. Shah Medical College,  
Jamnagar.  
Gujarat.  
Pin code: 361 008.  
Tel: 553515, Fax: 540036.

**KARNATAKA**

Bangalore Medical College,  
Fort, Bangalore  
Pin code: 560 002  
Tel: 6701150, 290289.



Adichunchanagiri Institute of Medical Sciences.  
A.C. Hospital & Research Centre, Bellur, Karnataka.  
Pin code: 571 448  
Tel: 08234-67533.

B.L.D.E.A.'s, Shri. B.M. Patil Medical College.  
Bijapur, Karnataka  
Pin code: 586 103.  
Tel: 21951 Fax: 08352-22609.

Father Muller's Hospital.  
Kankanady, Mangalore  
Karnataka.  
Pin code: 575 002.  
Tel: 436301

## **KERALA**

Government medical College.  
Trissur, Kerala.  
Pin code: 680 001.  
Tel: 421050.

Government Medical College.  
Calicut, Kerala  
Pin code: 673 008.  
Tel: 356531

## **MAHARASHTRA**

Krishna Hospital and Medical Research Centre.  
Near Dhebewadi Road, Karad,  
Satara. Maharashtra  
Pin code: 415 110  
Tel: 41555,41556.  
Fax: 42170.

Dr.P.D.M.M.College,  
Morshi Road, Amravati.  
Pin code: 444 602.  
Tel: 662323.



G.S.M.C.&K.E.M Hospital,  
Department of Psychiatry, KEM Hospital,  
Parel, Mumbai, Maharashtra.  
Pin code: 400 012.  
Tel: 4136051.  
Fax: 414-3435.

Government Medical College.  
Pandharpur Road.  
Miraj, District Sangli,  
Pin code: 416 410  
Tel: 222959.  
Fax: 0233-222959.

## **MADHYA PRADESH**

N.S.C.B. Medical college.  
Jabalpur, Madhya Pradesh.  
Pin code: 482 003.  
Tel: 422117.

M.G.M., Medical College,  
Indore, Madhya Pradesh  
Pin code: 452 001.

## **PUNJAB**

Dayanand Medical College & Hospital.  
Ludhiana, Punjab.  
Pin code: 141 001.  
Tel: 471500.

Medical College,  
Amritsar, Punjab  
Pin code: 143 001.  
Tel: 220618. Fax: 222506.

Government Medical College.  
Rajinder Hospital, Patiala,  
Punjab.  
Pin code: 147 001



## **TAMILNADU**

Chennai Medical College and Research  
Institute/Govt. General Hospital, Chennai.3.  
Chennai, Tamil Nadu.  
Pin code: 600 003.  
Tel: 563001.

Govt. Stanley Medical College & Hospital.  
Chennai, Tamil Nadu.  
Pin code: 600 001.  
Tel: 5261345.

Raja Muthiah Medical College.  
Annamalainagar; Chidabaram  
S. Arcot, Tamil Nadu.  
Pin code: 608 002.  
Tel: 22068.

Sri Ramachandra Medical College & Research Institute  
Porur, Chennai  
Pin code: 600116  
Tel: 4828027

## **UTTAR PRADESH**

B.R.D. Medical College,  
Gorakhpur,  
Uttar Pradesh  
Pin code: 273 013.  
Tel: 311736. Fax: 311 73

## **WEST BENGAL**

Bankura Sanmilani Medical College & Hospital.  
Govindanagar, Kendvadihi, Bankura.  
West Bengal.  
Pin code: 722 102.  
Tel: 51324.



North Bengal Medical College & Hospital.  
P.O.Sushrutanagar,  
Darjeeling. West Bengal  
Pin code: 734 432.  
Fax: 0353-450285.Tel: 471500.

TAMILNADU

Chennai Medical College and Research  
Institute Govt. General Hospital, Chennai 3.  
Chennai, Tamil Nadu.  
Pin code: 600 003.  
Tel: 263001.

Govt. Stanley Medical College & Hospital.  
Chennai, Tamil Nadu.  
Pin code: 600 001.  
Tel: 2261345

Raja Muthiah Medical College  
Ammalainagar, Chidambaram  
2. Arcot, Tamil Nadu.  
Pin code: 608 002  
Tel: 22068

Sri Ramachandra Medical College & Research Institute  
Porur, Chennai  
Pin code: 600 116  
Tel: 4838023

UTTAR PRADESH

B.R.I. Medical College,  
Gorakhpur,  
Uttar Pradesh  
Pin code: 273 013  
Tel: 211736 Fax: 111 73

WEST BENGAL

Banana Sumantra Medical College & Hospital,  
Govindnagar, Kandiakhali Bankura  
West Bengal  
Pin code: 725 103.  
Tel: 21324.

Government Medical College,  
Panipat Road,  
Meerut, Uttar Pradesh,  
Pin code: 221 410  
Tel: 221992  
Fax: 0333-222954.

MADHYA PRADESH

N.J.C.B. Medical college,  
Jabalpur, Madhya Pradesh.  
Pin code: 482 003.  
Tel: 432117

M.I.M. Medical College,  
Indore, Madhya Pradesh  
Pin code: 462 001.

PUNJAB

Dayanand Medical College & Hospital,  
Ludhiana, Punjab  
Pin code: 141 001.  
Tel: 471500.

Medical College,  
Amritsar, Punjab  
Pin code: 143 001  
Tel: 22618 Fax: 22300

Government Medical College,  
Rajinder Nagar, Patiala,  
Punjab  
Pin code: 147 001







